STATE OF FLORIDA
DEPARTMENT OF JUVENILE JUSTICE

BUREAU OF MONITORING AND QUALITY IMPROVEMENT

PROGRAM REPORT FOR

AMIkids Orlando

AMI Kids, Inc.

(Contract Provider)

1461 Lake Pleasant Rd.

Apopka, Florida 32703

Review Date(s): January 23-24, 2019

PROMOTING CONTINUOUS IMPROVEMENT AND ACCOUNTABILITY IN JUVENILE JUSTICE PROGRAMS AND SERVICES

Rating Definitions

Ratings were assigned to each indicator by the review team using the following definitions:

Satisfactory Compliance	No exceptions to the requirements of the indicator; or limited, unintentional, and/or non-systemic exceptions that do not result in reduced or substandard service delivery; or systemic exceptions with corrective action already applied and demonstrated.
Limited Compliance	Systemic exceptions to the requirements of the indicator; exceptions to the requirements of the indicator that result in the interruption of service delivery; and/or typically require oversight by management to address the issues systemically.
Failed Compliance	The absence of a component(s) essential to the requirements of the indicator that typically requires immediate follow-up and response to remediate the issue and ensure service delivery.

Review Team

The Bureau of Monitoring and Quality Improvement wishes to thank the following review team members for their participation in this review, and for promoting continuous improvement and accountability in juvenile justice programs and services in Florida:

Kamille Payne, Office of Program of Accountability, Lead Reviewer (Standard 1 and 4)
Tamara Mahl-Adkins, Office of Program Accountability, Regional Monitor (Standard 3 and 4)
Nichole McDonald, Project Manager, Chrysalis Health (Standard 2)
Rowena Rose, Office of Education, Education Specialist (Standard 2)
Bonita Williams, Office of Program Accountability, Regional Monitor (Interviews)
Sherri Wilson, Office of Program Accountability, Technical Assistance Specialist (SPEP)

Program Name: AMIkids Orlando
Provider Name: AMI kids, Inc.
Location: Apopka County / Circuit 9
Review Date(s): January 23-24, 2019

MQI Program Code: 1287
Contract Number: P2118
Number of Beds: 33
Lead Reviewer Code: 161

Methodology

This review was conducted in accordance with FDJJ-2000 (Contract Management and Program Monitoring and Quality Improvement Policy and Procedures), and focused on the areas of (1) Management Accountability, (2) Assessment and Intervention Services, (3) Mental Health and Substance Abuse Services, and (4) Medical Services, which are included in the Day Treatment Standards.

Persons Interviewed

☒ Program Director
☐ DJJ Monitor
☐ DHA or designee
☒ DMHCA or designee
1 # Case Managers
_____ # Clinical Staff
_____ # Food Service Personnel
_____ # Healthcare Staff
_____ # Maintenance Personnel
_____ # Program Supervisors
5 # Direct Care Staff
5 # Youth
_____ # Other (listed by title): _____

Documents Reviewed

☐ Accreditation Reports
☒ Affidavit of Good Moral Character
☒ CCC Reports
☐ Confinement Reports
☒ Continuity of Operation Plan
☒ Contract Monitoring Reports
☒ Contract Scope of Services
☒ Egress Plans
☐ Escape Notification/Logs
☐ Exposure Control Plan
☒ Fire Drill Log
☒ Fire Inspection Report
☒ Fire Prevention Plan
☐ Grievance Process/Records
☐ Key Control Log
☒ Logbooks
☒ Medical and Mental Health Alerts
☒ PAR Reports
☒ Precautionary Observation Logs
☒ Program Schedules
☐ Sick Call Logs
☒ Supplemental Contracts
☐ Table of Organization
☐ Telephone Logs
☒ Vehicle Inspection Reports
☐ Visitation Logs
☒ Youth Handbook
5 # Health Records
5 # MH/SA Records
6 # Personnel Records
6 # Training Records/CORE
3 # Youth Records (Closed)
7 # Youth Records (Open)
_____ # Other: _____

Observations During Review

☐ Admissions
☐ Confinement
☒ Facility and Grounds
☒ First Aid Kit(s)
☒ Group
☐ Meals
☐ Medical Clinic
☐ Medication Administration
☒ Posting of Abuse Hotline
☐ Program Activities
☐ Recreation
☒ Searches
☐ Security Video Tapes
☐ Sick Call
☒ Social Skill Modeling by Staff
☒ Staff Interactions with Youth
☒ Staff Supervision of Youth
☐ Tool Inventory and Storage
☐ Toxic Item Inventory and Storage
☐ Transition/Exit Conferences
☐ Treatment Team Meetings
☐ Use of Mechanical Restraints
☐ Youth Movement and Counts

Comments

Items not marked were either not applicable or not available for review.

Standard 1: Management Accountability
Day Treatment Rating Profile

Indicator Ratings

Standard 1 - Management Accountability		
1.01	Initial Background Screening*	Satisfactory
1.02	Five-Year Rescreening	Satisfactory
1.03	Protective Action Response (PAR)	Non-Applicable
1.04	Pre-Service/Certification Training	Satisfactory
1.05	In-Service Training	Satisfactory
1.06	Cleanliness and Sanatation	Satisfactory
1.07	Fire Prevention and Evacuation Procedures	Satisfactory
1.08	Water Activities	Non-Applicable
1.09	Food Services	Satisfactory
1.10	Transportation	Satisfactory
1.11	Administration	Satisfactory
1.12	Incident Reporting (CCC)*	Limited
1.13	Abuse-Free Enviorment*	Satisfactory
1.14	Behavior Management System	Satisfactory
1.15	Youth Record	Satisfactory

* The Department has identified certain key critical indicators. These indicators represent critical areas that require immediate attention if a program operates below Department standards. A program must therefore achieve at least a Satisfactory Compliance rating in each of these indicators. Failure to do so will result in a program alert form being completed and distributed to the appropriate program area (detention, residential, probation)

Standard 2: Assessment and Intervention Services
Day Treatment Rating Profile

Indicator Ratings

Standard 2 - Assessment Services		
2.01	Admission and Orientation	Satisfactory
2.02	Medical, Mental Health, and Suicide Risk Alerts in JJIS	Satisfactory
2.03	Positive Achievement Change Tool (PACT) Full Assessment	Satisfactory
2.04	Transitional Planning/Reintegration*	Satisfactory
2.05	Youth-Empowered Success (YES) Plan Development	Satisfactory
2.06	Youth Requreiment/PACT Goal Elements	Satisfactory
2.07	YES Plan Implementation/Supervision	Satisfactory
2.08	Ninety-Day YES Plan Updates	Satisfactory
2.09	Ninety-Day Supervisory Reviews	Satisfactory
2.10	PACT Reassessment	Satisfactory
2.11	Progress Reports	Satisfactory
2.12	Education Transition Plan	Satisfactory
2.13	Termination Release	Satisfactory
2.14	Career Education	Satisfactory
2.15	Educational Access	Satisfactory

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Standard 3: Mental Health and Substance Abuse Services
Day Treatment Rating Profile

Indicator Ratings

Standard 3 - Intervention Services		
3.01	Designated Mental Health Clinician Authority or Clinical Coordinator	Satisfactory
3.02	Licensed Mental Health and Substance Abuse Clinical Staff*	Satisfactory
3.03	Non-Licensed Mental Health and Substance Abuse Clinical Staff	Satisfactory
3.04	Mental Health and Substance Abuse Admission Screening*	Satisfactory
3.05	Mental Health and Substance Abuse Assessment/Evaluation	Satisfactory
3.06	Mental Health and Substance Abuse Treatment	Satisfactory
3.07	Treatment and Discharge Planning	Satisfactory
3.08	Mental Health Crisis Intervention Services*	Satisfactory
3.09	Crisis Assessments*	Satisfactory
3.10	Emergency Mental Health and Substance Abuse Services*	Satisfactory
3.11	Baker and Marchman Acts*	Satisfactory
3.12	Suicide Prevention Services*	Satisfactory
3.13	Suicide Precaution Observation Logs*	Satisfactory
3.14	Suicide Prevention Plan*	Satisfactory
3.15	Suicide Prevention Training*	Satisfactory

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Standard 4: Medical Services
Day Treatment Rating Profile

Indicator Ratings

Standard 4 - Medical, Mental Health, and Substance Abuse Services		
4.01	Medical Screening*	Satisfactory
4.02	Medication Management - Verification of Medications	Satisfactory
4.03	Medication Management - Delivery of Medications	Satisfactory
4.04	Medication Management - Medication Storage	Satisfactory
4.05	Episodic/Emergency Services	Satisfactory

* The Department has identified certain key critical indicators. These indicators represent critical areas that require immediate attention if a program operates below Department standards. A program must therefore achieve at least a Satisfactory Compliance rating in each of these indicators. Failure to do so will result in a program alert form being completed and distributed to the appropriate program area (detention, residential, probation).

Program Overview

AMIkids Orlando is a day treatment program operated by AMIkids, Inc. through a contract with the Department in Apopka, Florida. The program provides day treatment services to probation, minimum-risk commitment, and conditional release youth. The program is contracted to serve thirty-three male and female youth. The program fosters each youth by providing Aggression Replacement Therapy (ART). The program is comprised of an executive director, a lead case manager, one case manager, one contract licensed mental health counselor, one community safety specialist, and a transportation specialist. Mental health and healthcare services are provided through a contract with the individual licensed mental health counselor who was an employee of AMIkids, Inc. until December 13, 2018. The program provides mental health and substance abuse treatment utilizing individual therapy, ART, and Cannabis Youth Treatment (CYT). The program's services are designated to address criminogenic risk factors, according to the youth's needs and risks. The program provides facility-based delinquency programming and treatment to include case management services, strategic interventions, restorative justice, gender-specific services, substance abuse testing, and food services. The program provides medical services for the youth in the program by screening the youth for medical concerns and assisting the youth with medications if the youth take prescription medications during the time they are at the program. At the time of the annual compliance review, the program had one vacancy, the business manager, for which the program provided an exemption.

Strengths and Innovative Approaches

- The program operates in partnership with the Orange County School Board to provide an alternative school setting for youth and opportunities to enhance the education experience. The program operates a workshop where youth receive hands-on experience in working in different trades to create their own projects. The workshop also houses a collection of clothing for youth to use for events or take home, if they are unable to purchase their own.
- The program has a partnership with the Habitat for Humanity of Apopka and Greater Orlando where youth are transported to work sites to assist with tasks such as sodding, framing, and painting.
- The program also has a partnership with AmeriCorps to come into the program and provide mentoring services to the youth.
- While at the program, youth are able to obtain their State of Florida identification card through the Florida Licensing on Wheels (FLOW) program, a ServSafe Food Handler certification, and a National Center for Construction Education and Research (NCCER) certification.

Standard 1: Management Accountability

1.01 Initial Background Screening (Critical)	Satisfactory Compliance
Background screening is conducted for all Department employees and volunteers and all contracted provider and grant recipient employees, volunteers, mentors, and interns with access to youth. A contract provider may hire an employee to a position that requires background screening before the screening process is completed, but only for training and orientation purposes. However, these employees may not have contact with youth or confidential youth records until the screening is completed, the rating is eligible and the employee demonstrates that he or she exhibits no behaviors that warrant the denial or termination of employment. An Annual Affidavit of Compliance with Level 2 Screening Standards is completed annually.	

The program has a written policy and procedures in place requiring a background screening to be conducted on all new employees, volunteers, mentors, and interns prior to hire. The program had one new staff and two new volunteers during the annual compliance review period. The new staff and both of the new volunteers had a completed and eligible background screening in the Agency for Healthcare Administration Clearinghouse prior to hire. A pre-employment assessment tool, the Diana Screen, was found in the one new staff's record with a passing score. Additionally, there was evidence in the staff's personnel record of the provider verifying the criminal history report, Central Communications Center (CCC) person involvement report, Staff Verification System (SVS) module, and the Florida Department of Law Enforcement (FDLE) Automated Training Management System (ATMS) prior to hire. The program submitted their Affidavit for Compliance with Level 2 Screening Standards on January 10, 2019. Teachers at the program are employed by the Orange County School District, who submitted their Annual Affidavit of Compliance with Level 2 Screening Standards on January 25, 2018, meeting the annual requirement.

1.02 Five-Year Rescreening	Satisfactory Compliance
Background rescreening/resubmission is conducted for all Department employees and volunteers and all, contracted provider and grant recipient employees, volunteers, mentors, and interns with access to youth and confidential youth records. Employees and volunteers are rescreened every five years from the initial date of employment. When a current provider staff member transitions into the Clearinghouse, the rescreen/resubmission date starts anew and is calculated by the Clearinghouse. (Note: For the new date, see the Retained Prints Expiration Date on the applicant's personal profile page within the Clearinghouse.)	

The program has a written policy and procedures in place requiring each staff, volunteer, mentor, and volunteer to complete a background rescreening every five years of employment. A review of staff and volunteer rosters found one staff member eligible for a background screening and the staff was found to have a complete and eligible background screening in the Agency for Healthcare Administration Clearinghouse system within the required timeframe.

1.03 Protective Action Response (PAR)	Non-Applicable
The program uses physical intervention techniques in accordance with Florida Administrative Code. Any time staff uses a physical intervention technique, such as countermoves, control techniques, takedowns, or application of mechanical restraints (other than for regular transports), a PAR Incident Report is completed and filed in accordance with the Florida Administrative Code.	

The program has not had any PAR incidents during the annual compliance review period; therefore, this indicator rates as non-applicable.

1.04 Pre-Service/Certification Training	Satisfactory Compliance
Contracted non-residential staff are trained in accordance with Florida Administrative Code. Contracted non-residential staff satisfies pre-service/certification requirements specified by Florida Administrative Code within 180 days of hiring. *Contracted non-residential staff who have not completed essential skills training, as defined by Florida Administrative Code, do not have any direct contact with youth.* *Contracted non-residential staff who have not completed pre-service/certification training do not have direct, unsupervised contact with youth.*	

The program has a written pre-service training plan, which was submitted to the Department's Office of Staff Development and Training on December 27, 2018. The program had one staff eligible for completion of pre-service/certification requirements. The one eligible staff was found to have completed 212.5 hours of pre-service training documented in the Department's Learning Management System (SkillPro), including Protective Action Response (PAR), cardiopulmonary resuscitation (CPR)/first aid, suicide prevention, and professionalism and ethics training prior to contact with youth. SkillPro documented the staff also completed all other required trainings within the first ninety days of hire. Certifications were provided to demonstrate all instructors who facilitated PAR and first aid/CPR classes were qualified to deliver the training.

1.05 In-Service Training	Satisfactory Compliance
Contracted non-residential staff completes in-service training in accordance with Florida Administrative Code. Contracted non-residential staff must complete twenty-four hours of annual in-service training, beginning the calendar year after the staff has completed pre-service training. *Supervisory staff shall complete eight hours of training in the areas listed below, as part of the twenty-four hours of annual in-service training.*	

The program has a written in-service training plan, which was submitted to the Department's Office of Staff Development and Training December 27, 2018. All trainings are scheduled and tracked throughout the year on an in-service training calendar, which may be updated as necessary. Five staff training records were reviewed and documented each staff completed well over the required amount of in-service training, each logging between sixty-four and a half hours and 206 hours. Each of the five staff completed required training in cardiopulmonary resuscitation (CPR)/first aid, suicide prevention, and professionalism and ethics. None of the staff received Protective Action Response (PAR) training in 2018; however, documentation

revealed PAR training was provided to staff on December 27, 2017 and January 3, 2019. The PAR training was scheduled for late December in 2018 but was moved back due to the holidays, making it three days late. The program provided a training calendar for 2019 which included an additional PAR training in June 2019. Three of the five staff were eligible for supervisory training. One staff was found to have completed twenty hours, one staff had twenty-one hours, and the last staff had eighty-two hours of supervisory training in the areas of management, leaderships, personal accountability, employee relations, and communication skills. All in-service training was documented in the Department's Learning Management System (SkillPro) and certifications were found for all instructors who facilitated PAR and first aid/CPR training.

1.06 Cleanliness and Sanitation	**Satisfactory Compliance**
The program provides a safe and appropriate treatment environment including maintenance and sanitation of the facility.	

The program has a written policy and procedures in place outlining a cleanliness and sanitation plan for the facility. Weekly sanitation and safety inspections were found to be conducted to ensure the program is a safe and appropriate treatment environment for youth. In addition, the program completed a daily physical plant checklist and a monthly program safety evaluation to monitor and address any physical plant needs. A tour was completed upon arrival to the program for the annual compliance review and found all indoor areas to be neat, clean, well-maintained, and free of graffiti. The program only operates during the day; therefore, grounds are not required to be lit. There are separate bathrooms in the large group room/dining hall for males and females. The program had ample, appropriate space for education, groups, individual sessions, and other treatment activities.

1.07 Fire Prevention and Evacuation Procedures	**Satisfactory Compliance**
The program provides a safe and appropriate treatment environment including fire prevention and evacuation procedures.	

The program has a written policy and procedures regarding safety, fire prevention, and evacuation procedures. The policy prohibits smoking on facility grounds. Five staff in-service training records were reviewed, and each staff was found to have completed training in fire safety at least twice a year. A tour of the program revealed there are seven fire extinguishers at each egress door and in the shop and kitchen, nine pull boxes throughout the program, placed in each room, and egress plans posted throughout the facility. Documentation supported fire protection equipment is checked at least monthly by staff, checked and serviced at least annually by a third party vendor, and discussed at the monthly safety meetings. Unannounced fire safety drills were conducted at least monthly, and often twice a month, during the annual compliance review period at different times of day. All information related to fire and facility safety was maintained in a safety log, which also included a copy of the annual inspection conducted by the fire marshal. Five youth and five staff were interviewed and each reported knowing what to do in case of a fire.

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

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

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

The program contracts with the Orange County School District to provide food services to youth. All food is prepared off-site and brought to the program for youth meals. The program has a prep kitchen which was found to be clean and well maintained. Separate refrigerators are kept for youth and staff items. Youth eat in the large group area which also functions as the dining hall. The program maintains youth alerts which includes allergy information and special diets. Six youth were applicable for and provided alternative diets based on allergy and special diet information. A rotating four-week menu was found for the school year and included alternative food for youth with allergies. As the food is provided by the school district, staff are not offered the same menu as the youth but are able to purchase a meal if they choose to do so; this practice was confirmed through interviews conducted with five staff. Five youth were interviewed but were not able to report if staff are offered the same menu due to the arrangements with the school district. The program's behavior management system outlines food is never withheld as a disciplinary measure.

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

The program provides transportation to and from the program through program vehicles or providing bus passes to the youth. Additionally, the program provides transportation for off-campus activities. The program never denies services or penalizes a youth for lack of transportation, which was documented in youth case notes. The program maintains three vehicles, a bus, a van, and a truck; however, the truck does not transport youth. Each vehicle has current registration and insurance, along with the transport log maintained in a binder kept inside each vehicle. Each vehicle was also found to maintain a fire extinguisher, operational seat belts, and to be in good repair. The bus contained a first aid kit, which is stored underneath the front passenger seat, and was found to maintain all approved items. First aid kits are checked out when either of the other two program vehicles are utilized. The transportation specialist completes a daily inspection of each vehicle and completes a contraband check before and after all transports. Additionally, youth are also searched before and after transports and any contraband confiscated is documented in a contraband log. Five staff were interviewed and each reported youth and staff wear their seatbelts at all times. Five youth were interviewed and four reported seatbelts are worn at all times, one youth reported they do not always wear seatbelts. The vehicles were found to be locked when not in use.

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

The program's Executive Director is responsible for administration and oversight at the program, including maintaining and reporting information to the Department. The program maintains all required statistical information and submits all contract-required reports to the contract manager each month. The program's census was found to match the census in the Department's Juvenile Justice Information System (JJIS). Additionally, three closed youth records were reviewed and each youth's admission and discharge date maintained by the program matched the information entered into JJIS. The program maintains a daily logbook used to track program information such as schedule, activities, and any incidents. The logbooks are kept by month in a spiral bound book. Each day has its own two pages and there are spaces for each staff member's signature, identifying them by title. The Executive Director reviewed the logbook on a daily basis, while on-site and no less often than on a weekly basis if not on site each day. Logbook entries included the date, time, initials of the staff member completing the entry, youth and staff involved, and any pertinent information.

1.12 Incident Reporting (CCC) (Critical)	Limited Compliance
The program provides a safe and appropriate treatment environment including transportation. Whenever a reportable incident occurs, the program notifies the Department's Central Communications Center (CCC) within two hours of the incident, or within two hours of becoming aware of the incident.	

The program has a written policy and procedures which requires notifying the Department's Central Communications Center (CCC) of any reportable incidents. The program had five CCC reports assigned to them during the annual compliance review period, two of which were not applicable as they were called in by a Juvenile Probation Officer (JPO) regarding youth absconding from supervision. Each of the three applicable CCC reports were reviewed, two were regarding youth absconding from the program and called in by the program, and one was for a staff arrest. For each of the three CCC reports, the CCC was notified within the required two hour timeframe and documentation found the incident was discussed during the morning all-staff meeting. The program maintains a binder to track internal incidents and CCC reports. A report was found from September 24, 2018 in which two youth engaged in an altercation and the sheriff's office responded to the incident and arrested one youth; however, there was no corresponding report to the CCC. The program acknowledged they did not report this incident and was observed providing training to staff members on CCC reporting while the annual compliance review team was on-site. Additionally, the incident was then called into the CCC.

1.13 Abuse-Free Environment (Critical)	Satisfactory Compliance
Any knowledge or suspicion of abuse, abandonment or neglect is reported to the Florida Abuse Hotline.	

The program has a written policy and procedures to outline the requirement of providing an abuse-free environment for youth and staff. The program adheres to a code of conduct in compliance with Florida Statute 39.201 and requires all staff to sign an affidavit of good moral character upon hire, which was demonstrated in each of the six staff personnel records (one pre-service and five in-service) reviewed. A review of Central Communications Center (CCC)

reports, internal incident reports, and youth records found no incidents of allegations of abuse against staff during the annual compliance review period. Five staff were interviewed and each described the process for allowing youth to call the Florida Abuse Hotline as immediate and unimpeded. Further, staff never witnessed another staff member withholding youth from making a call to the Florida Abuse Hotline. Five youth were interviewed and each reported never having to make a call to the Florida Abuse Hotline. Each of the five youth also reported never hearing staff curse at youth, threaten or intimidate youth, and felt safe at the program. Four of the youth reported staff are respectful when talking to youth, one youth said staff are not always respectful but did not provide additional details.

1.14 Behavior Management System	**Satisfactory Compliance**
The program utilizes a behavior management system providing privileges and consequences to encourage youth to fulfill programmatic and education expectations. Consequences are fair and directly correlate with the behavior problem. The use of facility restriction does not exceed seven consecutive days. Disciplinary procedures are carried out promptly. Youth are not allowed to have control over or discipline other youth. Time-out is used in accordance with Florida Administrative Code. All behavior problems, time-outs, in-facility suspensions, and privilege suspensions are documented in the facility log and case file in accordance with Florida Administrative Code.	

The program has a written policy and procedures outlining the behavior management system (BMS), which includes the program cannot deny youth participation in recreation, meals, healthcare services, contact with parent/guardian, or legal assistance as punishment. The BMS is based on a three-part system of points, levels, and a token economy. Youth are able to earn points each day which allows them to earn incentives through the token economy, offered on Thursdays, and progress through the levels to earn additional privileges. The token economy store is organized by level and includes food items, clothing, toys, and hygiene items. The program also created a game room for youth in the highest level to use during their lunch period. Points are documented on individual point cards. The program provides youth the rules and expectations of the program at orientation, including a document which outlines rule violations and their consequences. Consequences at the program include loss of points or level, detention, in-school suspension, work detail, an essay, and law enforcement involvement, if required. The program does not utilize time outs; this was confirmed through an interview with five youth. Four youth reported youth are never allowed to punish other youth. One youth reported youth could punish other peers; however, would not provide additional information. In addition to the BMS guidelines, the program orientation packet also includes the Department and program mission statements. Postings were found throughout the program and on the youth’s individual point sheets regarding behavioral expectations. Levels are tracked on a shadow board in the large group room.

1.15 Youth Records (Healthcare and Management)	**Satisfactory Compliance**
The program maintains an official case record, labeled “Confidential,” for each youth, which consists of two separate files: ▪ *An individual healthcare record* ▪ *An individual management record.*	

The program utilizes an electronic document system, Lauris, to maintain all youth records. Lauris is a restricted system which requires a password and permissions to access, ensuring records are kept confidential. All case management, mental health, and medical information is

kept in Lauris. Information on youth legal information, demographic and chronological information, correspondence, case management and treatment team activities, and miscellaneous information is maintained for all youth as demonstrated by information printed from the case record in Lauris.

Standard 2: Assessment and Intervention Services

2.01 Admission and Orientation	Satisfactory Compliance
Facility orientation shall be conducted within twenty-four hours of a youth's admission to the facility. Case notes should document the date and time of the orientation and the youth received orientation documents.	

The program has a written policy and procedures in place outlining the admission and orientation process. Five youth case records were reviewed, four of which were applicable for admission and orientation; the remaining youth record reflected the youth was admitted to the program prior to the annual compliance review period. For each of the four applicable youth, orientation was conducted within twenty-four hours of the youth's admission date, found on the youth's Face Sheet. Case notes documented the date and time of each orientation and confirmation the youth received orientation documents. An orientation handbook was provided to each youth and contained all required elements. In addition to the handbook, the orientation included the following: introduction to program staff and a tour of the facility grounds, a review of expectations, rules, the behavior management system, a review of the daily activity schedule governing day-to-day operations, a review of emergency medical and mental health services, emergency safety and the evacuation procedures for the program, a list of contraband items and materials, the consequences for introducing contraband into the facility, a review of the performance planning process, the average anticipated length of stay to successfully complete the program, and the program's dress code.

2.02 Medical Alerts, Mental Health Alerts, and Suicide Risk Alerts in JJIS	Satisfactory Compliance
The program shall alert staff of medical, mental health, and suicide risk issues that may affect the security and safety of the youth in the program.	

The program has a written policy and procedures for the identification and documentation of medical, mental health, and suicide risk alerts. Five youth records were reviewed, three youth had documented medical conditions, five had a documented suicide risk alert, and two had a mental health alert which required an alert to be entered into the Department's Juvenile Justice Information System (JJIS). Each alert was placed into JJIS immediately upon staff gaining knowledge of the alert and each alert was downgraded by the appropriate staff member. All alerts are maintained in a program alert binder and discussed at the daily all-staff morning meeting. Environmental stressors and any other pertinent program or youth information is also shared at the morning meeting. Five staff were interviewed and each confirmed the process for being informed of alerts and reported this process was very good.

2.03 Positive Achievement Change Tool (PACT) Full Assessment	Satisfactory Compliance
The PACT Full Assessment is completed by program staff for all youth, regardless of risk to reoffend, within seven calendar days of admission.	

The program has a written policy and procedures requiring a Positive Achievement Change Tool (PACT) Full Assessment to be completed for each youth within seven days of admission. Five youth case records were reviewed, four of which were applicable for the admission PACT, one youth record reflected the youth was admitted to the program prior to the annual

compliance review period. Each of the four applicable youth records reflected the PACT Full Assessment was completed on the day of admission.

2.04 Transition Planning/Reintegration (Critical)	Satisfactory Compliance
Program staff actively participates in the transitional planning process for youth who are being released from a residential program on conditional release (CR) or post-commitment probation (PCP). For conditional release and post-commitment probation youth, the YES Plan must address recommendations from the residential program during transition.	

The program has a written policy and procedures in place regarding transition planning and reintegration for youth on post-commitment probation who were referred to the program while in a residential commitment program. Five youth records were reviewed and one was applicable for transition planning and reintegration; therefore, two additional youth records were reviewed. Each youth's Juvenile Justice Information System (JJIS) case notes documented the program maintained monthly contact with the youth, parent/guardian, and program while the youth was in a commitment program. The case notes also reflected the Case Manager had at least one telephonic contact with the youth during their transition period. One of the youth was applicable for a face-to-face contact and did not have one; however, the program documented attempts to arrange contact with the program. Each youth was referred to the program after their transitional conference but prior to their Exit Conference. One of three youth's case notes reflected the case manager participated in the Exit Conference. For the other two youth, the case manager documented multiple e-mails to the program to try and solicit the Exit Conference information but was not successful.

2.05 Youth-Empowered Success (YES) Plan Development	Satisfactory Compliance
The YES Plan (Form DJJ/PACTFRM 4) is cooperatively developed for youth on Probation, Conditional Release, and Post-Commitment Probation. Youth and parent/guardian signatures do not indicate cooperative development of the YES Plan.	

The program has a written policy and procedure regarding development of the Youth-Empowered Success (YES) Plan. Five youth case records were reviewed and each had an initial YES Plan developed within fourteen days of admission and after administration of a Positive Achievement Change Tool (PACT) Full Assessment. Case notes in the Department's Juvenile Justice Information System (JJIS) reflected the YES Plans were developed cooperatively with the youth, parent/guardian, and Case Managers. The case notes also reflected the youth and parent/guardian were informed of the importance of compliance with goals, signed the YES Plan, and received a copy of the plan. One youth was applicable for integration of residential commitment Exit Conference recommendations into the YES Plan, along with the two additional applicable youth records reviewed. The program reported, and case notes reflected, the program requested but did not receive the Discharge Summary for each of the three youth in order to integrate the recommendations into the YES Plan. Five youth were interviewed and each knew their YES Plan goals, four reported they received a copy of their YES Plan, and one reported they never received a copy of the plan.

2.06 Youth Requirement/PACT Goal Elements	Satisfactory Compliance
The YES Plan provides appropriate and individualized target dates for the completion of each youth requirement and PACT goal. All youth requirement and PACT goal action steps include the intervention plan elements (i.e., who, what, and how often).	

The program utilizes each youth's court ordered sanctions and results of the Positive Achievement Change Tool (PACT) Full Assessment to develop the Youth-Empowered Success (YES) Plan goals. Five youth records were reviewed and each youth's YES Plan included goals with appropriate action steps for the Case Manager, youth, and parent/guardian, and target dates for completion. Additionally, each youth had one of their top three criminogenic needs, identified on the PACT, addressed as a Change Goal in their YES Plan and documented in the Department's Juvenile Justice Information System (JJIS). Four of the five youth had all court-ordered sanctions included on their YES Plan; one youth's YES Plan was missing restitution ordered by the court. Five youth were interviewed and each was aware of their YES Plan goals.

2.07 YES Plan Implementation/Supervision	Satisfactory Compliance
Youth on supervision (i.e., probation, conditional release, or post-commitment probation) are supervised in a manner ensuring compliance with the court order and completion of YES Plan (youth requirements and PACT goals). Case notes demonstrate compliance (or attempted compliance) with youth, parent/guardian, and staff action steps contained in the YES Plan.	

The program has a written policy and procedures regarding supervision of youth through the implementation of the youth's Youth-Empowered Success (YES) Plan. Five youth case notes were reviewed and each documented Case Manager (CM), youth, and parent/guardian compliance with YES Plan action steps and sanctions. Further, case notes reflected all written and verbal correspondence between the CM, youth, parent/guardian, school, Juvenile Probation Officer (JPO), and any additional collateral sources, as well as included activities at the program, home visits, telephone calls, and other contacts. The case notes demonstrated the program maintains quality contact with the youth and parent/guardian.

2.08 Ninety-Day YES Plan Updates	Satisfactory Compliance
Staff adjust the YES Plan to reflect any new needs and progress made during the course of supervision. Staff must make necessary updates to youth requirements and PACT goals and save a new YES Plan in the Juvenile Justice Information System (JJIS) prior to ninety-day supervisory reviews. When updates are made to the YES Plan reasonably requiring the input of the youth and parent/guardian, this discussion is clearly documented in the case notes. Use of the "case notations" or a similar form the youth and/or parent/guardian initials to indicate the YES Plan was reviewed does not signify compliance. The case notes clearly document any communication regarding the YES Plan.	

The program has a written policy and procedures requiring ninety-day Youth Empowerment Success (YES) Plan updates for each youth. Five youth records were reviewed and four reflected each ninety-day update was completed within the required timeframe and included all changes made in the Department's Juvenile Justice Information System (JJIS) and updates documented and discussed with the youth and parent/guardian. One youth record reflected the first ninety day YES Plan update was due November 6, 2018; however, it was not completed until December 3, 2018, twenty-five days late. The program reported a new Case Manager (CM) was responsible for completing the update and provided corrective action and training for the

CM as a result of the error, along with a tracker which was implemented to prevent any updates from being late in the future.

2.09 Ninety-Day Supervisory Reviews	Satisfactory Compliance
Cases under supervision (i.e., probation, conditional release, post-commitment probation) are reviewed by the supervisor at least once every ninety calendar days. The supervisor ensures staff review any instructions given during the review, and ensures they were followed during the subsequent review.	

The program has a written policy and procedures requiring supervisory reviews every ninety days. Five youth records were reviewed and four reflected a supervisory review was conducted at least every ninety days to ensure requirements and Change Goals were updated in the Department's Juvenile Justice Information System (JJIS). One supervisory review was conducted twenty-five days late, as the Case Manager completed the YES Plan update twenty-five days after it was due. The program reported a new CM was responsible for completing the update and provided corrective action and training for the CM as a result of the error, along with a tracker, which was implemented to prevent any updates from being late in the future.

2.10 PACT Reassessment	Satisfactory Compliance
Staff complete PACT Reassessments for youth on probation, conditional release, and post-commitment probation, as well as minimum-risk non-residential commitment youth. Regardless of risk to reoffend, the PACT Full Assessment is completed every 180 days.	

The program has a written policy and procedures in place requiring a Positive Achievement Change Tool (PACT) Reassessment to be completed at least every 180 days. Five youth records were reviewed and each reflected a PACT Reassessment was completed within the required timeframe. An additional three closed youth records were reviewed and two records reflected an Exit PACT was completed within fourteen days of discharge. One youth record reflected the Exit PACT was completed twenty-eight days prior to the youth's discharge.

2.11 Progress Reports	Satisfactory Compliance
Progress reports are completed detailing the youth's progress with the youth requirements and PACT goals outlined in the YES Plan.	

The program has a written policy and procedures in place regarding completion of a progress report every ninety days. Five youth records were reviewed and each included documentation of progress reports sent to the youth's parent/guardian and Juvenile Probation Officer (JPO) monthly. The progress reports included information from the most recent treatment team meeting with a cover letter summarizing the youth's progress and date of the next treatment team meeting. Each youth's case notes reflected the youth were given an opportunity to review and sign the report. Additionally, signatures were found for the Case Manager completing the report and the Executive Director on each report. None of the youth required progress reports to be forwarded to the State Attorney's Office or youth's attorney.

2.12 Education Transition Plan	Satisfactory Compliance
Staff and youth complete an Education Transition Plan prior to release including provisions for continuation of education and/or employment.	

Three closed case management records were reviewed for an educational transition plan. Documentation reflects each youth was involved in the transition process and included responsibility requirements. Identified potential barriers to youth's post-commitment success is addressed in the transition plan. Transition goals listed in each youth's performance plan contained employability skills. Additionally, the responsible party was identified for each transition activity. The services were based on individual needs and included provisions for continued education and/or employment. A Career Source letter was included in the records. Each closed record had a résumé, employment application, and all appropriate documents essential to obtaining employment. The program bell schedule and logbooks for October 2, 2018, October 3, 2018, and December 7, 2018 were reviewed and indicated minimal interferences of educational instruction.

2.13 Termination/Release	Satisfactory Compliance
The program shall recommend termination to the Department for youth on probation, conditional release, or post-commitment probation, as well as minimum-risk commitment youth, upon successful completion of court-ordered sanctions and substantial compliance with restitution and/or court fees. *For youth on probation, conditional release, or post-commitment probation, the program works with the JPO/CM to facilitate the release of the youth upon completion of the program.* *For youth on minimum-risk commitment or conditional release, staff completes the Pre-Release Notification and Acknowledgement (PRN) (DJJ/BCS Form 19) and follows the required procedure.*	

The program has a written policy and procedures regarding the termination and release of youth from the program. Three closed youth records were reviewed and each reflected the program recommended the youth's discharge to the Department and worked with the youth's Juvenile Probation Officer (JPO) to facilitate the youth's release from the program. For each of the youth, the JPO, not the Case Manager, was responsible for requesting a warrant and charges check and notifying the court. One youth was a minimum-risk committed youth; a Pre-Release Notification (PRN) was found for this youth and submitted along with a progress report. The program updated the Department's Juvenile Justice Information System within five days of discharge from the program for each youth and notified the youth and parent/guardian the youth was no longer under the supervision of the program.

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

The program provides a competent career education and vocational development program. The career education programming is a Type 2 and services are appropriate to the age group and ability level to help maintain employment and living standards. The program addresses youth with employability goals such as completing an employment application, completion of a resume summarizing education, work experience, and career training. The career education program

uses the following assessment tools: MyCareerShines, Job Readiness Course (Certificate) and Job Safety Course (Certificate). Assessment tools are utilized to enhance youth communication, interpersonal skills, employability skills, independent living skills and decision-making skills. Three closed youth case management records with employability goals were reviewed and each had evidence of an appointment with the Career Source Center and involvement of the Juvenile Probation Officer and the parent/guardian with the vocational plan. The plan also included specific plans for continuation of education and employment for each youth.

2.15 Educational Access	Satisfactory Compliance
The program shall integrate educational instruction (career and technical education, as well as academic instruction) into their daily schedule in such a way ensuring the integrity of required instructional time.	

The bell schedule/master schedule was reviewed to confirm the program provides 250 days of instruction distributed over twelve months; a minimum of twenty-five hours a week. The program and the Orange County Public Schools system, which provides educational services for youth at the program, provide professional development for all instructional staff. An interview with the lead teacher confirmed the school schedule. The lead teacher reported the school provides vocational opportunities for youth, including an opportunity to earn a National Center for Construction Education and Research (NCCER) certification. The program was recently given approval for youth to receive credit for the NCCER course in the 2019-2020 school year.

Standard 3: Mental Health and Substance Abuse Services

3.01 Designated Mental Health Clinician Authority or Clinical Coordinator	Satisfactory Compliance
Each program director is responsible for the administrative oversight and management of mental health and substance abuse services in the program. Programs with an operating capacity of 100 or more youth, or those providing specialized treatment services, must have a single licensed mental health professional designated as the Designated Mental Health Clinician Authority (DMHCA) who is responsible for coordinating and verifying implementation of necessary and appropriate mental health and substance abuse services in the program. Programs with an operating capacity of fewer than 100 youth or those not providing specialized treatment services, may have either a DMHCA or a Clinical Coordinator.	

The program has a Designated Mental Health Clinician Authority (DMHCA), who was an employee of the program, but has been contracted since December 13, 2018. The DMHCA did not have a sign-in log due to being an employee prior to December 13, 2018; the program is in the process of utilizing a sign in log to document the contracted DMHCA's hours on-site. A review of the DMHCA's license showed it being clear and active in the State of Florida, expiring on March 31, 2019. The DMHCA interview described her role in the coordination and implementation of mental health (MH) and substance abuse (SA) services in the program, including how often she is on-site. The DMHCA indicated she completes the initial treatment plans, provides each youth an orientation to MH and SA services, conducts Assessments of Suicide Risk (ASR), if necessary, and updates all mental health and suicide risk alerts. The DMHCA also completes comprehensive MH/SA evaluations and treatment planning and provides treatment to the youth and families. The DMHCA works 9 a.m. to 5 p.m., five to seven days a week.

3.02 Licensed Mental Health and Substance Abuse Clinical Staff (Critical)	Satisfactory Compliance
The program director is responsible for ensuring mental health and substance abuse services are provided by individuals with appropriate qualifications. Clinical supervisors must ensure clinical staff working under their supervision are performing services they are qualified to provide based on education, training, and experience.	

The program has one licensed mental health professional, which is the Designated Mental Health Clinician Authority (DMHCA), working on-site who is a licensed mental health counselor (LMHC) with a clear and active license in the State of Florida, expiring March 31, 2019. There are no other clinical staff employed or contracted with the program. The program holds a license in accordance with Chapter 397, F.S. to provide substance abuse services for level 1 prevention. The license became effective on September 2, 2018 and is expiring September 1, 2019.

3.03 Non-Licensed Mental Health and Substance Abuse Clinical Staff	Satisfactory Compliance
The program director is responsible for ensuring mental health and substance abuse services are provided by individuals with appropriate qualifications. Clinical supervisors must ensure clinical staff working under their supervision are performing services they are qualified to provide, based on education, training, and experience.	

The program has written facility operating procedures addressing the non-licensed mental health (MH) and substance abuse (SA) clinical staff qualifications, credentials, licenses, and experiences. The program did not have any non-licensed MH/SA clinical staff during this annual compliance review period.

3.04 Mental Health and Substance Abuse Admission Screening (Critical)	Satisfactory Compliance
The mental health and substance needs of youth are identified through a comprehensive screening process ensuring referrals are made when youth have identified mental health and/or substance abuse needs or are identified as a possible suicide risk.	

Five youth records were reviewed for the mental health and substance abuse admission screening, four of which were applicable. One record reflected the youth was admitted prior to the annual compliance review period. In the four applicable records, the lead Case Manager, who is trained in the administration of the Positive Achievement Change Tool (PACT) and the Massachusetts Youth Screening Instrument, Second Edition (MAYSI-2), conducted the screening at the time of admission to the program. The staff reviewed all available information and utilized the Department's Juvenile Justice Information System (JJIS) forms. As a result of the screening, all four youth required a referral for completion of an Assessment of Suicide Risk (ASR) and mental health (MH) and substance abuse (SA) evaluation. Each assessment was conducted within a twenty-four-hour time frame; on the same day. During the admission process, each of the four youth and their parent/guardian received information regarding MH and SA individual, group, and family therapy services provided by the program, as well as behavioral therapy, psychosocial skills training, and referrals made for psychiatric services and developmental disability services for youth in need. The program's facility operating procedures also specify youth shall have access to MH and SA screenings, comprehensive MH and SA evaluations, individualized MH and SA treatment planning, treatment plan reviews, and discharge planning, as well as suicide prevention services, crisis intervention, and emergency MH and SA services. Upon result of the screening, the Executive Director/designee were notified, a referral was made to the Designated Mental Health Clinician Authority (DMHCA), a suicide risk alert was entered into JJIS and the ASR was completed for each of the four youth. In three of the four records, the program staff completed the PACT MH/SA referral form on the day of admission. In the fourth record, the form was not completed. The program utilizes the MH/SA referral summary form MHSA 014.

3.05 Mental Health and Substance Abuse Assessment/Evaluation	Satisfactory Compliance
Youth identified by screening, staff observation, or behavior after admission and in need of further evaluation must be referred for a Comprehensive Mental Health Evaluation or Comprehensive Substance Abuse Evaluation or Updated Evaluation.	

Five youth records were reviewed for the mental health and substance abuse assessment/evaluation, four of which were applicable. One record reflected the youth was

admitted prior to the annual compliance review period. In the four applicable records, the youth was referred on the date of admission to receive a new mental health/substance abuse (MH/SA) evaluation. In three of the four records, the MH/SA evaluation was completed within thirty days of the referral; the fourth was two days late. All four evaluations were completed by the Designated Mental Health Clinician Authority (DMHCA) and included demographic information of the youth, reason for the evaluation, relevant background information, behavioral observation, mental status exam, interview/procedures administered, methods of assessment, patterns of alcohol and other drug abuse, impact of alcohol and other drug abuse on major life areas, risk for continued alcohol and other drug use, discussion of the findings, clinical impression including Diagnostic and Statistical Manual diagnosis, diagnostic impressions and the findings/recommendations. In each of the four records, the new MH/SA assessment addressed the original referral reason.

3.06 Mental Health and Substance Abuse Treatment	Satisfactory Compliance

Mental health and substance abuse treatment planning in departmental facilities/programs focuses on providing mental health and/or substance abuse interventions and treatment to reduce or alleviate the youth's symptoms of mental disorder and/or substance abuse impairment and enable youth to function adequately in the juvenile justice setting.
The treatment team is responsible for assessing the youth's rehabilitative treatment needs and assisting in developing, reviewing, and updating the youth's individualized and initial mental health/substance abuse treatment plans.

Five youth records were reviewed for the mental health and substance abuse assessment/evaluation, four of which were applicable. One record reflected the youth was admitted prior to the annual compliance review period. In each of the four applicable records, the youth was assigned to a Multidisciplinary Treatment Team at the time of admission, which included the direct care staff, mental health (MH) and substance abuse (SA) counselor, administration, and educational staff. All four records maintained a Consent and Release for Treatment Form signed by the youth regarding SA treatment, as well as a signed Authority for Evaluation and Treatment (AET) form to receive MH treatment. Each of the four youth received MH and SA treatment in accordance with each youth’s initial or individualized MH/SA treatment plan and the MH and/or SA treatment notes were documented on a form which contained all of the elements of the Department’s MHSA 018 form. Treatment notes and group sign-in sheets were reviewed and verified all mental health groups had ten or less youth in attendance and substance abuse groups had fifteen or less youth in attendance.

3.07 Treatment and Discharge Planning	Satisfactory Compliance

Youth determined to have a serious mental disorder and/or substance abuse impairment, and are receiving mental health and/or substance abuse treatment in a program, must have an initial or individualized mental health or substance abuse treatment plan. When mental health or substance abuse treatment is initiated, an initial or individualized mental health/substance abuse treatment plan is completed. When both mental health and substance abuse treatment is initiated, an integrated mental health and substance abuse treatment plan is completed.
All youth who receive mental health and/or substance abuse treatment while in a day treatment program will have a discharge summary completed documenting the focus and course of the youth's treatment and recommendations for mental health and/or substance abuse services upon youth's release from the facility.

Five youth records were reviewed for the mental health and substance abuse assessment/evaluation, four of which were applicable. One record reflected the youth was admitted prior to the annual compliance review period. In each of the four applicable records, the initial treatment plan was developed on the day of admission and was completed on a document which included all of the elements of the Department's form. None of the initial treatment plans were applicable for psychiatric services. The plans were signed by the Designated Mental Health Clinician Authority (DMHCA), the youth, the parent/guardian, and other treatment team members. The individualized MH/SA treatment plan was completed in three of the four applicable records within thirty days of admission; the remaining plan was completed two days late. The individualized MH/SA treatment plan was completed on a document which included all of the elements of the Department's form. The plans were signed by the DMHCA, the youth, the parent/guardian, and the treatment team members. In two of the four plans, the interventions included psychiatric needs. The program conducted individualized MH/SA treatment plan reviews on a form which contained all of the elements of the Department's form and included the DMHCA and youth signatures. The reviews were conducted every thirty days as required in three of the four applicable records. The remaining one record had one treatment plan review which was conducted ten days late; out of fifteen reviews in the four records, one was late.

Three closed records were reviewed and found the discharge plans were completed at transition/discharge. Two of the records had documentation the plan was discussed with the youth, parent/guardian, and Juvenile Probation Officer (JPO) during the Exit Conference; the remaining record did not have the discussion with the JPO documented. The MHSA treatment discharge summary considered services needed for daily maintenance of the positive improvement in behavioral, emotional, and social skills made by the youth during treatment. A copy of the summary was provided to the youth, parent/guardian, and JPO for each of the three youth.

3.08 Mental Health Crisis Intervention Services (Critical)	**Satisfactory Compliance**
Every program must respond to youth in crisis in the least restrictive means possible to protect the safety of the youth and others while maintaining control and safety of the facility. The program must be able to differentiate a youth who has an acute emotional problem or serious psychological distress which would require mental health crisis interventions from one who requires emergency services. A youth in crisis does not pose an imminent threat of harm to himself/herself or others which would require suicide precautions or emergency treatment.	

The program's written facility operating procedures contain the integrated crisis intervention and mental health/substance abuse (MH/SA) services emergency care plan, including the elements of notification and alert system, referral, self-referral and assessment, communication, supervision, documentation and review.

3.09 Crisis Assessments (Critical)	Satisfactory Compliance
A Crisis Assessment is a detailed evaluation of a youth demonstrating acute psychological distress (e.g., anxiety, fear, panic, paranoia, agitation, impulsivity, rage) conducted by a licensed mental health professional, or non-licensed mental health professional working under the direct supervision of a licensed mental health professional, to determine the severity of youth's symptoms, and level of risk to self or others. When staff observations indicate a youth's acute psychological distress is extreme/severe and does not respond to ordinary intervention, the program director or designee must be notified of the crisis situation and need for crisis assessment. A Crisis Assessment is to be utilized only when the youth's crisis (psychological distress) is not associated with suicide risk factors or suicide risk behaviors. If the youth's behavior or statements indicate possible suicide risk, the youth must receive an Assessment of Suicide Risk instead of a Crisis Assessment and the procedures for a suicide risk alert must be followed.	

The program's written facility operating procedures (FOP) contain the integrated crisis intervention and mental health/substance abuse (MH/SA) services emergency care plan. Five in-service training records were reviewed and each staff received crisis intervention training, which was documented in the Department's Learning Management System (SkillPro). Of the five youth records reviewed, none received a crisis assessment. The program did not utilize crisis assessments during the annual compliance review period.

3.10 Emergency Mental Health and Substance Abuse Services (Critical)	Satisfactory Compliance
Youth determined to be an imminent danger to themselves or others due to mental health or substance abuse emergencies occurring in facility require emergency care provided in accordance with Rule 63N-1, F.A.C., and the facility's emergency care plan.	

The program's written facility operating procedures (FOP) contain the integrated crisis intervention and mental health/substance abuse services emergency care plan, which included procedures for immediate staff response, notifications, communication, supervision of youth, authorization to transport for emergency services, transportation for emergency mental health and/or substance abuse evaluation and treatment, documentation, training to include mock drills, and the review process. The plan was signed on September 5, 2018 by the Designated Mental Health Clinician Authority (DMHCA) and the Executive Director.

3.11 Baker and Marchman Acts (Critical)	Satisfactory Compliance
Individuals who are believed to be an imminent danger to themselves or others because of mental illness or substance abuse impairment require emergency mental health or substance abuse services.	

The program has a written facility operating procedures (FOP) regarding Baker and Marchman Acts. None of the five reviewed records were for a youth who received a Baker Act or Marchman Act; however, the program was able to provide the only applicable record for review. The one applicable youth was placed on precautionary observation (PO) during an individual counseling session with the Designated Mental Health Clinician Authority (DMHCA) due to signs of suicide risk. The suicide PO log was maintained until the youth was taken by law enforcement to be Baker Acted. The DMHCA completed an Assessment of Suicide Risk (ASR) while law

enforcement was on-site, which recommended the Baker Act, but also documented transitioning the youth from PO to standard supervision. The DMHCA reported she transitioned the youth to standard supervision because the youth was leaving the program and was no longer under their supervision. The youth was transported to the Baker Act facility and, prior to release, was discharged from the program.

3.12 Suicide Prevention Services (Critical)	Satisfactory Compliance
Suicide Precautions are the methods utilized for supervising, observing, monitoring, and housing youth identified through screenings, available information, or staff observations as having suicide risk factors. *Any youth exhibiting suicide risk behaviors must be placed on Suicide Precautions (Precautionary Observation), and a minimum of constant supervision.* *All youth identified as having suicide risk factors by screening, information obtained regarding the youth, or staff observations, must be placed on Suicide Precautions and receive an assessment of suicide risk.*	

Five youth records were reviewed, of which four were applicable for requiring suicide prevention services during the annual compliance review period. In the four applicable records, the youth were determined to be at risk during the admission screening process. The youth were placed on precautionary observation (PO) on the date of admission, a referral for an Assessment of Suicide Risk (ASR) was immediately completed, and an ASR was completed utilizing the Department required form. PO was authorized and a Juvenile Justice Information System (JJIS) suicide risk alert was entered. Mental health staff provided supportive services and an ASR was completed prior to the youth being removed from PO. The ASR documented a conference was conducted between the Executive Director and the Designated Mental Health Clinician Authority (DMHCA), prior to reducing the supervision level of the youth. The discontinuation of PO was documented in accordance with the program's suicide prevention plan. The suicide risk assessment was conducted by the DMHCA and the results in all four records was to discontinue PO and place the youth on standard supervision. The ASR was completed within twenty-four hours of screening/concern and the suicide precaution observation log was completed in its entirety. A review of the logbooks indicated documentation was made regarding youth being placed on PO, as well as stepped down to standard supervision, and instructions provided by the DMHCA and Executive Director related to suicide risk assessment findings made on the ASR.

3.13 Suicide Precaution Observation Logs (Critical)	Satisfactory Compliance
Youth placed on suicide precautions must be maintained on one-to-one or constant supervision. The staff member assigned to observe the youth must provide the appropriate level of supervision and record observations of the youth's behavior at intervals no greater than thirty minutes.	

Five youth records were reviewed, four of which were applicable for youth placed on precautionary observation (PO) during the annual compliance review period. Each of the four applicable records contained observation logs for each instance of PO, which were reviewed and signed by each shift supervisor, as well as daily by the Designated Mental Health Clinician Authority (DMHCA). The program documented safe housing areas and youth supervision on the observation logs in intervals not to exceed thirty minutes for the duration of the suicide

precaution status. None of the youth observed had any warning signs requiring follow-up while on PO.

3.14 Suicide Prevention Plan (Critical)	Satisfactory Compliance
The program follows a suicide prevention plan to safely assess and protect youth with elevated risk of suicide in the least restrictive means possible in accordance with Rule 63N-1, Florida Administrative Code.	

The program has written facility operating procedures (FOP), which contain the suicide prevention plan. The plan includes the elements of identification and assessment of youth at risk of suicide, staff training, suicide precautions, levels of supervision, referral, communication, notification, documentation, immediate staff response, and the review process.

3.15 Suicide Prevention Training (Critical)	Satisfactory Compliance
All staff who work with youth must be trained to recognize verbal and behavioral cues indicating suicide risk and suicide prevention and implementation of suicide precautions.	

The program has a written in-service training plan which requires staff to complete at least six hours of suicide prevention training annually. Five in-service training records were reviewed and each staff received ten hours of training regarding suicide prevention and implementation of suicide precautions, which was also documented in the Department's Learning Management System (SkillPro). Documentation supported the program conducted at least one mock suicide drill each quarter and all program staff participated in each drill. Five staff were interviewed and each staff was able to explain what to do when a youth expressed suicidal thoughts, including documenting supervision of the youth, two staff members stated they notify the supervisor or Executive Director, and four indicated to provide constant sight and sound supervision. Staff also stated other steps for when youth express suicidal ideation to include to call the parent/guardian, the director will advise staff on what to do, the therapist shall be notified, staff will see the youth and will complete documentation and evaluate the youth to determine if the youth should be placed on supervision, and the Juvenile Probation Officer (JPO) needs to be notified. Four of the interviewed staff reported the "Knife for Life," wire cutters, and needle-nose pliers (suicide response kit) are kept in the lead case manager's office and one stated in the therapist's office.

Standard 4: Medical Services

4.01 Medical Screening (Critical)	Satisfactory Compliance
Youth are screened for health-related conditions at the time of admission to determine if the youth has any conditions requiring medical attention. The screening includes a review of the most recent Health Discharge Summary (Form HS 012) or Medication receipt/transfer disposition (Form HS 053), if applicable, and documented contact with the parent/guardian if there are any questions or concerns regarding the youth's medical condition. Screening may be performed by non-licensed staff during the admission process. All medical, mental health, and substance abuse information is documented in the youth's Individual Health Care Record.	

The program has a written policy and procedures requiring staff to complete a medical screening during each youth's admission. Five youth records were reviewed, four of which were applicable for a medical screening. One youth was admitted to the program prior to the annual compliance review period. In each of the four applicable records, both a medical screening and a Facility Entry Physical Health Screening (FEPHS) form was found. On each screening form, staff documented contact with the youth's parent/guardian regarding any medical issues, and all information was documented in the program's electronic management system, Lauris. The program did not have access to any of the youth's most recent health discharge summary from other programs or centers.

4.02 Medication Management – Verification of Medications	Satisfactory Compliance
The program shall determine a youth's medication regimen upon admission to the program.	

The program has a written policy and procedures in place regarding the verification of medications upon a youth's admission to the program, if the medications are to be administered by program staff. Five youth records were reviewed, two of which were applicable for medications at admission; however, none of the youth required verification of medications, as their medications were never taken on-site. The program reported none of the youth required verification of medications during the annual compliance review period.

4.03 Medication Management – Delivery of Medications	Satisfactory Compliance
The program shall have a process in place to assist youth with self-administration of oral medications.	

The program has a written policy and procedures in place regarding the delivery of medications which articulates required training for staff to administer medications to youth and the procedures for administration of medications. The procedures include ensuring staff assisting in medication administration are only responsible for medication delivery, maintaining control of the medication containers, confirming allergy status, side effects, and adverse reactions, and ensuring the Five Rights of Medication Administration are upheld. Five program staff have documented training in assisting youth in the self-administration of medications. The program reported none of the youth were applicable for the delivery of medications during the annual compliance review period. A review of the medication distribution log confirmed no medications were administered on-site and the log was reviewed by supervisory staff on a weekly basis. Five youth and five staff were interviewed and each reported youth do not received medications on site. The five staff interviewed also reported they are informed of medication side effects for

medications youth are taking at home through the alert list which is discussed in the morning meetings.

4.04 Medication Management – Medication Storage	Satisfactory Compliance
All medications (prescriptions, over-the-counter (OTC), topical, etc.) shall be stored in separate, secure (locked) areas inaccessible to youth and ensures proper inventory control.	

The program has written facility operating procedures (FOP) in place articulating the program's process for storing medications, including how the medications are to be returned once the youth has completed the program. The program does not maintain any medication on-site but does have storage containers located in the Designated Mental Health Clinician Authority's (DMHCA) office, which are clean and free from moisture and extreme temperatures, and are locked, when not in use. There are two small locked boxes, one for topical medications, which was a small black box, and the other was a beige box for oral medications or controlled substances, neither had any medications contained in them. The office also had a small refrigerator utilized for refrigerated medications, which was also empty and locked.

4.05 Episodic/Emergency Services	Satisfactory Compliance
The program shall have a comprehensive process for the provision of Episodic Care, First Aid, and Emergency Care. The program shall be capable of facilitating an appropriate response to an emergency situation.	

The program has written facility operating procedures (FOP) in place clearly articulating how the program would facilitate a response to an urgent or emergency medical situation. The program's FOP states cardiopulmonary resuscitation (CPR) techniques must be demonstrated and drills conducted on a quarterly basis Additionally, all emergency events are to be documented in the program's logbook and communicated during staff meetings. Drills were found for medical emergencies, including the demonstration of CPR/first aid, completed once a quarter. The program does not have an automated external defibrillator (AED) on-site. The program has one main first aid supply kit/box in the lead Case Manager's (CM) office and one extra first aid kit, which is utilized in the vehicle during transport. The vehicle first aid kit is kept inside the program and taken when transportation occurs. The wire cutter, needle-nose pliers, and knife-for-life are maintained in the lead CM's office in the first aid supply kit/box. The first aid kits and knife-for-life are monitored on a minimum of a monthly basis by the operational staff. The program completed mock emergency medical drills at least quarterly, as well as completing CPR demonstration training once a quarter. The program also conducted mock suicide drills at least once a quarter with all staff working with youth. The emergency numbers are posted on the desk of the staff members, inaccessible to the youth. According to the Executive Director, the program did not have any off-site emergency care events or any episodic care measures, as well as no death or serious adverse medical events during this annual compliance review period which was confirmed through a review of the logbook.

Program Name: AMIkids Orlando
Provider Name: AMIkids, Inc.
Location: Apopka County / Circuit 9
Review Date(s): January 23-24, 2019

MQI Program Code: 1287
Contract Number: P2118
Number of Beds: 33
Lead Reviewer Code: 161

Overall Rating Summary

The following limited and/or failed indicators require immediate corrective action.

Limited Ratings	Failed Ratings
1.12 Incident Reporting (CCC)*	