STATE OF FLORIDA
DEPARTMENT OF JUVENILE JUSTICE

BUREAU OF MONITORING AND QUALITY IMPROVEMENT

PROGRAM REPORT FOR

AMIkids Tallahassee

AMIkids, Inc.

(Contract Provider)

2541 West Tharpe Street

Tallahassee, Florida 32303

Review Date(s): November 27-29, 2018

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:

Ken Phillips, Office of Program of Accountability, Lead Reviewer (Standard 1)
Jill Foy, Office of Program Accountability, Regional Monitor (Standard 2)
Juan Youman, Office of Program Accountability, Regional Monitor (Standard 3 and 4)

Program Name: AMIkids Tallahassee
Provider Name: AMIkids, Inc.
Location: Leon County / Circuit 2
Review Date(s): November 27-29, 2018

MQI Program Code: 1237
Contract Number: P2107
Number of Beds: N/A
Lead Reviewer Code: 145

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
- **1** # Clinical Staff
- _____ # Food Service Personnel
- _____ # Healthcare Staff
- **1** # Maintenance Personnel
- **1** # Program Supervisors
- **5** # Staff
- **5** # Youth
- _____ # Other (listed by title): **Lead Teacher**

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
- **5** # Personnel Records
- **5** # Training Records/CORE
- **3** # Youth Records (Closed)
- **5** # Youth Records (Open)
- _____ # Other: _____

Interviewed

- **5** # Youth
- _____ # Direct Care Staff
- _____ # Other: _____

Observations During Review

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

Comments

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

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)	Satisfactory
1.04	Pre-Service/Certification Training	Satisfactory
1.05	In-Service Training	Satisfactory
1.06	Cleanliness and Sanatation	Satisfactory
1.07	Fire Prevention and Evacuation Procedures	Satisfactory
1.08	Water Activities	Non-Applicable
1.09	Food Services	Satisfactory
1.10	Transportation	Satisfactory
1.11	Administration	Satisfactory
1.12	Incident Reporting (CCC)*	Satisfactory
1.13	Abuse-Free Enviorment*	Satisfactory
1.14	Behavior Management System	Satisfactory
1.15	Youth Record	Satisfactory

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

Standard 2: Assessment and Intervention Services
Day Treatment Rating Profile

Indicator Ratings

Standard 2 - Assessment Services		
2.01	Admission and Orientation	Satisfactory
2.02	Medical, Mental Health, and Suicide Risk Alerts in JJIS	Satisfactory
2.03	Positive Achievement Change Tool (PACT) Full Assessment	Satisfactory
2.04	Transitional Planning/Reintegration*	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	Limited
3.08	Mental Health Crisis Intervention Services*	Satisfactory
3.09	Crisis Assessments*	Satisfactory
3.10	Emergency Mental Health and Substance Abuse Services*	Satisfactory
3.11	Baker and Marchman Acts*	Non-Applicable
3.12	Suicide Prevention Services*	Satisfactory
3.13	Suicide Precaution Observation Logs*	Limited
3.14	Suicide Prevention Plan*	Satisfactory
3.15	Suicide Prevention Training*	Failed

* 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 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	Limited

* 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 1: Management Accountability

Overview

AMIkids Tallahassee provides day treatment services for twenty-two youth between the ages of fourteen and eighteen. The program consists of an executive director, regional care counselor, local care counselor, and a community safety specialist, who also serves as the program's bus driver. In addition, the program has a part-time business manager and mental health professional. Educational services are provided through a contractual agreement between the program and Leon County District Schools. The program has a written behavior management system, which is designed to give youth the understanding of their negative behaviors while being able to identify their behaviors from effective redirection and counseling.

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 hired one staff member since the last annual compliance review. In addition, the program's educational component had one teacher who was also hired during this time. A review of both staffs' personnel records found each received an initial background screening, and were found to be eligible for hire prior to their initial start date. Neither staff were direct care staff and did not require the pre-employment assessment tool. An interview with the executive director revealed the program did not have any contracted or grant provider volunteers, mentors, and interns who worked with the youth on an intermittent basis for less than two hours with access to confidential information. The program submitted the Annual Affidavit of Compliance with Level 2 Screening Standards to the Background Screening Unit (BSU) on November 29, 2017, meeting the annual requirement. The program provided documentation of the 2018-2019 contract for educational services between the school board of Leon County and AMIKids. Terms of the contractual agreement include background checks required for all agency employees who come in contact with students as part of the educational program.

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.)	

A review of all program staff dates of hire revealed one staff was eligible for a five-year re-screening. The re-screening was completed within the staff's five-year anniversary date. The

staff's re-screening resulted in a determination of eligible for employment. A review of the employee roster and an interview with the executive director revealed the program did not have any volunteers which may require a re-screening.

1.03 Protective Action Response (PAR)	Satisfactory Compliance
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 a written policy and procedures which defines and describes the authorized levels of response and Protective Action Response (PAR) techniques, as well as documentation and retention of records related to PAR incidents and reporting requirements. Based on a review of the program records and an interview with the executive director, the program did not have any PAR incidents for the scope of the annual compliance review. The program has a PAR plan which was approved by the Department's Office of Staff Development and Training on December 29, 2017.

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 policy and procedures which defines pre-service training requirements for staff. The provider submits their pre-service training plan annually to the Department's Office of Staff Development and Training. A review of this documentation found the plan was submitted and approved on December 29, 2017. The program did not have direct care or full-time employees hired during the scope of the annual compliance review, who required the pre-service training requirements. The program hired a part-time mental health professional (MHP) during the annual compliance review period. A review of the staff's training records found evidence the staff received training in cardio pulmonary resuscitation (CPR) and first aid. Instructors are qualified to provide training through the American Red Cross. The MHP is responsible for completing the Assessment of Suicide Risk (ASR) for youth and has received the minimum twenty-hours of required training in assessing suicide risk, as well as training in behavior management, client rights, crisis intervention and de-escalation procedures, and treatment model and program philosophy.

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 policy and procedures in place regarding in-service training requirements. The provider's in-service training plan is submitted annually to the Department's Office of Staff Development and Training which includes course name, descriptions, objectives, and training hours for instructor-led training. A review of this plan revealed it was submitted on January 7, 2018. The program's annual in-service training plan may be updated as changes occur. The program documents the training in the Department's Learning Management System (SkillPro). A review of four staff training records, which included one supervisory staff, revealed all four staff exceeded the minimum twenty-four hours of the required in-service training. One staff received seventy-six and a third hours, two staff received forty-three and a half hours, and one staff received forty-one and a half hours. All four staff received training for cardio pulmonary resuscitation (CPR), first aid, and automated external defibrillator (AED). All staff also received trainings for professionalism and ethics, and emergency response training. One of four staff exceeded the six-hours minimum training required for suicide prevention. One staff lacked three hours of this training, and two staff lacked one hour each of the minimum training hours required. The executive director was made aware of the staff lacking the minimum required training hours. There was no formal corrective action taken. One staff was applicable for review of the additional supervisory training required in areas such as management, leadership, personal accountability, employee relations, communication skills, and fiscal requirements. The staff's training records revealed completion of twenty-five and a half hours, which exceeded the minimum requirement of eight hours.

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 which addresses program cleanliness and maintenance, to ensure the program provides a safe and appropriate treatment environment which includes maintenance and sanitation of the facility. Observations were made during the annual compliance review. All indoor areas throughout the program were clean, neat, and well maintained. The program grounds were landscaped and free from trash or debris. There were no observations of graffiti or insect infestation throughout the facility. In addition, program furnishings, tables, and chairs appeared to be in good form. The bathroom facilities are separated by gender. All bathrooms were clean and included antibacterial soap for handwashing. There was adequate space for meals, private counseling, group facilitation, and educational classes. The program's community safety specialist (CSS) is primarily responsible for conducting weekly sanitation and safety inspections of all internal and external areas, and equipment. Documentation of the inspection checks are completed on the weekly facility checklist forms. A review of all forms found overall consistency with this practice with few exceptions. Forms were not present for one week in the month of September, and two weeks in

June, July, and August. In addition to the weekly facility checklist, the CSS also conducts emergency light checklist monthly. A review of this completed documentation found evidence the emergency light checks are completed consistently. An interview with the CSS revealed in the event any major maintenance is required, the work is contracted to outside vendors for completion. Maintenance request and repair forms are provided in the program and are submitted to the executive director or CSS for follow-up as required.

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 fire prevention and evacuation procedures. Observations made during the annual compliance review found evidence fire protection equipment is available throughout all program areas of the facility, as well as within the one program vehicle. All extinguishers are checked monthly by the community safety specialist (CSS). Observations of the extinguisher inspection tags was documented as required. In addition to fire protection equipment, the program conducts fire drills monthly, at a minimum. Evidence of these drills were observed to be documented and maintained in a drill binder. Drills were reviewed for the scope of the annual compliance review and were conducted on the following dates: May 31, June 29, July 30, August 31, September 28, and October 1, 2018. The program maintains a fire safety log, which includes documentation of the annual safety inspection completed on March 23, 2018, conducted by the State Fire Marshall Office. There were no fire safety violations indicated. The program has evacuation and/or egress plans posted throughout all program areas and within each classroom. The program prohibits smoking in the facility and designated smoking areas are located outside. Four staff training records were reviewed for training in fire safety and awareness. Two of the four staff had the training documented in the Department's Learning Management System (SKillPro) as part of their in-service training requirements. Five youth were interviewed. Three of five interviewed youth reported they had been instructed as to what to do in the event of a fire. An interview with the CSS revealed instructions are given to new youth upon admission concerning fire prevention and evacuation procedures.

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 any water-related activities. Therefore, this indicator rates as non-applicable.

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

The program has a written policy and procedures concerning food services. The policy indicates the program is not permitted to withhold food from youth for disciplinary reasons. An interview with the executive director revealed the program contracts with an outside vendor to provide breakfast and lunch each day for the youth. The meals are provided through the National

School Lunch Program. Delivery of the meals and youth consuming the meals were observed during the annual compliance review. Food service areas were clean and well maintained. Youth consume meals in the common area. There were no trash or food debris observed on floors. Five interviewed youth reported the program offers the same menu for both staff and youth. All five youth also reported the program provides special diets to youth for health reasons or to accommodate religious beliefs. Four of five interviewed staff reported the same menu is available for both staff and youth.

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

The program has one vehicle used to transport youth. Youth are not denied services based on lack of transportation. The program's community safety specialist (CSS) is the single person responsible for operating the vehicle. A review of the documentation revealed the CSS has a current and valid Florida driver's license, with is validated by the human resources officer, according to the executive director. The program's vehicle was observed in good condition and was observed during youth transports. The vehicle had current insurance and registration. Documentation was observed of daily vehicle maintenance checklists completed by the CSS. Observations of the vehicle also found evidence of a first aid kit and fire extinguisher. Seatbelts are worn by the driver when in use, as the vehicle is a standard school bus. Each youth, upon admission, receives a student handbook which includes information on the transportation procedures. The handbook includes rules to follow during transports. Five youth and five staff interviews were conducted. All five youth and staff reported seat belts are worn during transport activities.

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

The program has a written policy and procedures which establishes guidelines to provide a safe and appropriate environment, which includes administrative and operational oversight. The program submits monthly reports to the Department which details incidents and population data. The executive director provided examples of these reports. The program maintains statistical information such as invoice data and information within the Juvenile Justice Information System (JJIS). A review of five youth records and JJIS information found the date of admission and date of termination documented in each youth case management records. The closed records correlated with the Department's date in JJIS. The program maintains one unit logbook. A review of the logbook contents found program activities and significant events, and incidents were documented as required. Logbook entries included the dates and times of incidents, names of youth and program staff involved, a brief statement of pertinent information, and initials of the individual documenting in the logbook. Documentation was presented indicating the logbooks were reviewed and signed bi-weekly, at a minimum, by the executive director.

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

The program has a written policy and procedures which discuss guidelines and criteria for reporting information and incidents to the Central Communication Center (CCC). A review of the CCC incidents within the past six months was conducted through a search of the Juvenile Justice Information System (JJIS). A total of two incidents were discovered during this period. Each were reported by the program to the CCC within two hours of the program gaining knowledge of the incident. The program documents CCC reports in a operations binder. A review of internal incidents and grievance information found there were no other events which should have been reported to the CCC. Based on a review of the previous annual compliance review period, the program did not have an increase in their total number of CCC reporting incidents this reporting year.

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

An interview with the executive director revealed each new employee receives a Team Member Reference Guide, which serves as the employee handbook. The guide includes information regarding standards of conduct required by all staff. Since the last annual compliance review, the program had one incident involving allegations of abuse or neglect on a staff member. The information was reported to the Central Communications Center (CCC) within the two-hour required time frame. As a result of the incident, the staff involved was placed on administrative leave, and removed from all client contact pending an administrative review by the Department. Findings were determined the incident was substantiated and the staff was terminated from their employment. The program has a written policy and procedures which establishes the process by which any AMIkids staff member or volunteer knowingly, or has reasonable cause to suspect, a child is abused, abandoned, or neglected by a parent/legal guardian or other person responsible for the child's welfare, reports such knowledge or suspicion of abuse or neglect to the Florida Abuse Hotline. The program lists all employees as mandatory reporters. Observations of program areas found postings of emergency numbers for the Florida Abuse Hotline and CCC throughout program areas. Five interviewed youth all reported they feel safe in the program. All five youth reported they were never denied or prevented from reporting abuse. All five youth reported staff were respectful when talking with them or other youth. None of the five youth reported hearing staff use profanity, threatening youth, or asking youth to meet them socially after school times. Five staff were interviewed and all reported youth have the opportunity to contact the Florida Abuse Hotline or CCC if they wish to make a report. None of the five interviewed staff reported ever seeing a co-worker deny or prevent a youth from making a call to report abuse. None of the five interviewed staff reported hearing other staff use profanity or make threats towards other youth. The Monitoring and Quality Improvement reviewers completing additional standards for the annual compliance review were questioned regarding knowledge of any instances of abuse not reported to the Florida Abuse Hotline or CCC. All indicated the records reviewed did not indicate additional reporting should be made.

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's written policy and procedures describes the program's behavior management system (BMS) which provides privileges and consequences to encourage youth to fulfill programmatic expectations. Consequences are outlined and are fair and correlate with the behavior problem. The use of the program restrictions does not exceed seven consecutive days, according to the policy. Disciplinary procedures are carried out promptly. The BMS does not authorize group punishment or allow youth to discipline other youth. Time-out does not exceed one hour. All behaviors and incidents are required to be documented in the program's logbook. Examples of significant incidents were observed and documented, as required. Prior to any privilege or suspension, staff explain to youth the reason for the consequence or restrictions and give youth the opportunity to explain their behavior. Daily activities and program rules and expectations are posted in the program areas, as well as outlined in the student handbook. Each youth, upon admission, receives a student handbook which outlines the program's level and ranking system, as well as promotion requirements. Each youth receives a point card and are responsible for maintaining the cards throughout the day. The purpose of the cards is to capture points earned for following the program guidelines. Each student receives immediate feedback after each class period and throughout the course of the day. The program has a token economy system which students can earn "Bid Bucks" to purchase items in the token store. Five interviewed youth indicated there were no youth authorized to discipline or control other youth. All five interviewed youth reported they have never been placed in time-out while in the program.

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 separates the youth records into two separate records: an individual management record and an individual healthcare and mental health record. All records were observed marked confidential and were kept in a secured location inaccessible to youth. A review of the individual management record found each contained the youth's name, Department of Juvenile Justice identification number, date of birth, county of residence, and committing offense. Cabinets used to maintain records were clearly marked confidential.

Standard 2: Assessment and Intervention Services

Overview

The program provides day treatment, case management, and educational services to youth who have been placed on probation, post-commitment probation, and conditional release. The program has a regional care counselor (RCC) and one local care counselor (LCC) who provides case management services including: intake, program orientation, administration of the Positive Achievement Change Tool (PACT) Full Assessments, negotiation, formulation, amendments to and the monitoring of the Youth Empowered Success (YES) Plan, preparation of progress reports, and the facilitation of the termination of youth from services. The program also has a director of education and three teachers who provide educational services to the youth at the program.

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 which establishes guidelines as to the orientation and admission of all youth to the program. A review of five youth records revealed orientation was completed on the day of admission for each youth. Documentation in the case notebook reflected the date and time in which orientation was conducted as well as the youth acknowledgement of receipt of the youth handbook. Orientation in all five records was completed by the regional care counselor (RCC) or local care counselor (LCC) and included all required elements.

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 which provides guidelines as to actions required in the notifications to staff and within the Juvenile Justice Information System (JJIS) as they pertain to medical, mental health, and suicide risk issues which may affect the security and safety of the youth in the program. A review of five youth records reflected three youth were applicable for suicide alerts. A review of the five youth records indicated all were admitted to the program with a chronic condition. In each record, alerts were reflected on the program's internal alert roster and in the Juvenile Justice Information System (JJIS). The internal alert roster is maintained by the program's mental health professional (MHP) and is reviewed and signed daily by all staff members. An interview with five staff reported each reviews and signs the alert roster provided by the MHP. All five interviewed staff reported the alert roster was an effective way of communicating this information.

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 establishing protocols by which the program completes a Positive Achievement Change Tool (PACT) Full Assessment for every youth, regardless of risk to reoffend, within seven calendar days of admission. A review of four of the five youth records reflected the PACT full assessment was completed the day of admission. One youth record reflected the PACT was completed seven calendar days late.

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 describing the process of how program staff actively participates in the transition planning for youth who are being released from a residential program on conditional release (CR) or post-commitment probation (PCP). Five youth records were reviewed and one of the five records were applicable for transition planning. The program provided two additional records of youth who were applicable for transition planning. In all three cases, the referral for services at the program was submitted by the juvenile probation officer (JPO) thirty to sixty days after the youth was released from the residential program. Prior to the youth release date, referrals were submitted by the JPO to the aftercare and transition services with another provider. There were no examples of a youth being referred for service prior to the youth's release from a residential program since the last annual compliance review.

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 procedures describing the Youth-Empowered Success (YES) plan development. A review of five youth records reflected a PACT full assessment was completed prior to the development of the initial YES plan for all five youth. Documentation reflected four of the five YES plans were developed within fourteen calendar days of admission to the program. One YES plan was developed five days late. Case notes reflected participation of the required parties in the development of the YES plan. A copy of the YES plan was provided to the youth and the parent/guardian upon their review and signature. All five interviewed youth reported they participated in the development of their YES plan and three of the five interviewed youth reported they received a copy of their YES 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 has a written policy and procedures describing the Youth-Empowered Success (YES) plan will provide appropriate and individualized targets dates for completion of each youth requirement and Positive Achievement Change Tool (PACT) goal. A review of five youth records reflected court ordered sanctions were documented in the Juvenile Justice Information System (JJIS) youth requirements module. All youth requirements in all five records reflected actions steps for the youth, parent/guardian, and case manager clearly defined who is responsible, what action should be taken, and how often the action should be taken. In all five records, one of the youth's top three criminogenic needs were addressed in a change goal of the YES plan. Four of the five interviewed youth were able to report they were aware of their YES plan goals and were able to identify the goal they were currently working on.

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 describing youth on community supervision are supervised in a manner which ensures compliance with the court order and completion of Youth-Empowered Success (YES) plan goals. A review of case notes in all five youth records reflected demonstration of compliance or non-compliance by required parties, contacts with youth, parent/guardian, and other collateral sources.

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 outlining the process by which the Youth-Empowered Success (YES) plan is updated to reflect any new needs and progress made during supervision. Five youth records were reviewed and three were applicable for ninety-day supervisor updates. Two youth have not been in the program for ninety days. A review of the three applicable records reflected input of both the youth and the parent/guardian.

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 ensuring cases under supervision are reviewed by the supervisor at least once every ninety days and instructions given to staff during the review are followed in the subsequent review. Five youth records were reviewed and three were applicable for ninety-day supervisor reviews. Two of the youth have not been in the program for ninety days. Documentation in the three applicable records reflected ninety-day supervisor reviews were completed as required. Updates to the youth requirements and Youth Empowered Success (YES) plans were completed in the Juvenile Justice Information System (JJIS) prior to the supervisor reviews.

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

The program has a written policy and procedures ensuring a consistent practice of staff to complete Positive Achievement Change Tool (PACT) Reassessments for youth under supervision every 180 days. Five youth records were reviewed and two were applicable for a 180-day PACT Reassessment. Three of the youth were not applicable for a PACT Reassessment due to not being in the program for 180 days. Three closed records were also reviewed for reassessments. All applicable records reflected PACT Reassessments were completed, as required. Exit PACT Assessments were completed for three applicable youth within fourteen days of their release from the program.

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

The program has a written policy and procedures describing protocol whereby progress reports are prepared and distributed in accordance with Florida Administrative Code. Five youth records were reviewed and three were applicable for progress reports. None of the three applicable youth required a cover letter. Progress reports reflected each youth was given the opportunity to provide comments. All required parties signed and dated each progress report Documentation reflected the juvenile probation officer (JPO) was provided with the progress report.

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.	

The program has a written policy and procedures describing the process of how youth shall complete an education transition plan prior to successful completion of the program. Five youth records were reviewed for education transition plans. Documentation of each record reflected all

five youth received education transition plans upon admission and are currently ongoing. All five youth records reflected all key personnel were included on the education transition plan. One of the five reviewed records were applicable for employability. The program provided two additional records of youth who were applicable for employability as a transition goal for review. One of the three applicable records for employability did not contain a sample application or evidence of an appointment with the Career Source Center.

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 describing the process of the program recommending termination to the Department for youth on community supervision, conditional release, post-commitment probation, and minimum risk commitment. Three closed records were reviewed for termination or release. Program staff works with the juvenile probation officer (JPO) to conduct checks with local law enforcement to determine if there are outstanding warrants or charges for the youth. In each case documentation reflected the program recommended termination upon successful completion of the program. Two applicable records were reviewed for completion of a Pre-Release Notification (PRN). Documentation reflected a PRN and the final progress report was completed. None of the three youth records reviewed were applicable for loss of jurisdiction.

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

The program has a written policy and procedures defining career education is appropriate based upon the age, assessed educational abilities and goals of each youth in the program. The program provides Type Two educational programming which includes orientation to a broad scope of career choices, based upon personal abilities, aptitudes and interests, exploring, and gaining knowledge of different career options. Type One education content is also included in the Type Two program. Type One career education includes communication, interpersonal, and decision-making skills. Three applicable records were reviewed for career education. A review of one closed applicable record did not include a sample résumé or evidence of a Career Source Center appointment.

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 program has a written policy and procedures outlining the process for integration of education instruction into the program's daily schedule in such a way to ensure the integrity of the required instructional time. An interview with the lead teacher indicated youth attend class each day for 300 minutes. A review of the program's activity schedule supported this practice. Observations made during the annual compliance review, reflected the program is following the daily activity schedule and there was minimal interference with educational instruction. Youth receive course credit for the completion of the educational and training services.

Standard 3: Mental Health and Substance Abuse Services

Overview

AMIkids Tallahassee has a contract with a licensed clinical social worker (LCSW) who serves as the designated mental health clinical authority (DMHCA). The program employs one part-time mental health professional (MHP) who is not licensed. The MHP is supervised by the DMHCA. The program has mental health and substance abuse service plans which includes a suicide prevention plan, a mental health crisis intervention service plan, and an emergency mental health and substance abuse service plan. Staff receive training through mock drills and the Department's Learning Management System (SkillPro).

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.	

AMIkids Tallahassee has a licensed clinical social worker (LCSW) who serves as the program's designated mental health clinician authority (DMHCA). A check of the DMHCA's license was found to be clear and active in the State of Florida, with an expiration date of March 31, 2019. Although the contract between the DMHCA and the program does not give a specific number of hours required, there was documentation of the DMHCA being on-site for a minimum of one hour a week. The DMHCA's role is to provide consultation to the mental health counselor on a weekly basis and as needed.

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 and substance clinical staff. A check of the licensed mental health and substance abuse clinical staff's license was found to be clear and active in the State of Florida, with and expiration date of March 31, 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.	

AMIkids Tallahassee has one non-licensed mental health and substance clinical staff. There was documentation of the non-licensed counselor receiving an hour a week of face-to-face direct supervision from a licensed professional. The clinical supervision was documented on the Department's Mental Health and Substance Abuse (MHSA) 019 form. The non-licensed clinical staff holds a master's-level degree from an accredited university or college in the field of social work. There was documentation of the non-licensed clinical staff receiving training in basic counseling skills, basic group therapy skills, treatment model and program philosophy, therapeutic milieu, behavior management, client rights, crisis intervention, early intervention and de-escalation, documentation requirements, normal and abnormal adolescent development, and typical behavior problems. There was documentation of the non-licensed staff receiving twenty hours of training and supervised experience in assessing suicide risk, mental health crisis intervention, and emergency mental health services.

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.	

A review of five youth records revealed each youth was screened using the Massachusetts Youth Screening Instrument, Second Edition (MAYSI-2) and the Positive Achievement Change Tool (PACT) assessment upon admission. The screenings were completed by a trained staff in the Department's Juvenile Justice Information System (JJIS). The program staff reviewed each of the youth's available information, reports and records for existing documentation of mental health or substance abuse problems. All five of the youth had a referral for Assessment of Suicide Risk (ASR) and one of the youth were referred for a comprehensive mental health and substance abuse evaluation. The program director (PD) or designee was notified, and the ASR was completed within twenty-four hours of referral. There was documentation of a suicide risk alert entered in the Department's JJIS. The PD developed written facility operating procedures (FOPs) of a standardized admission/intake mental health and substance abuse screening process, containing all the required elements.

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.	

A review of five youth records were reviewed and one of the five youth were applicable of further evaluation and referred for a Comprehensive Mental Health or Substance Abuse Evaluation. Additional records were requested and the program provided one additional record for review. The review of the applicable records found evaluations were completed within thirty

days of referral and approved by a licensed professional within ten calendar days. Each of the new evaluations included all of the required elements.

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

A review of five youth records found each youth was assigned to a multidisciplinary treatment team upon arrival to the program to include a representative from direct care staff, mental health, administration, and educational staff. A review of all five youth records contained a signed Substance Abuse Consent and Release forms(MHSA 012 & 013) and an Authority for Evaluation for Treatment (AET).

3.07 Treatment and Discharge Planning	Limited 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.*	

A review of five youth records found two youth were applicable for treatment and discharge planning. The program provided an additional record for review to meet the sample size. Each of the three reviewed records contained an initial treatment plan which was developed within seven days of the initiation of treatment. Each of the initial plans were signed by the treatment team members who participated in the development of the plan. A review of the records revealed none of the three plans were signed by licensed staff within ten days, when the plan was developed by a non-licensed staff. The plans were signed two months and fifteen days late, twenty-seven days late, and three months and fourteen days late.
The program provided the review team with two discharge summaries. A review of the discharge summaries revealed one of the youth was successful and received a certificate of completion and the other youth was non successful in the completion of their treatment and remained in the program. The discharge summaries were discussed with the youth who successfully completed the treatment, the parent/guardian, and the assigned juvenile probation officer (JPO) during the exit conference. Copies of the discharge summaries were provided to the youth, the parent/guardian and the assigned JPO. None of the youth were on suicide risk alert or suicide precautions during the time of treatment at the program.

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 has a written crisis intervention plan to protect the safety of the youth and others while maintaining control and safety of the program. The crisis intervention plan details procedures to include notification and alert system, means of referral, including youth self-referral, communication, supervision, and 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.	

A review of five youth records found none of the youth were in need of a crisis assessment. A review of the program's written policy and procedures, crisis assessment tool, and staff training records revealed the program is adequately prepared for a crisis.

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 has an emergency care plan which was reviewed and approved by the executive director and the designated mental health clinician authority (DMHCA) on July 3, 2018. The plan includes all the following elements immediate staff response, notifications, communication, supervision, authorization to transport for emergency mental health or substance abuse services, transport for emergency mental health evaluation and treatment under Chapter 394 Florida Statutes (Baker Act), transport for emergency substance abuse assessment and treatment under Chapter 397 (Marchman Act) documentation training to include mock drills, and review process.

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

The program did not utilize a Baker Act or Marchman Act procedure during this review period; therefore, this indicator rates as non-applicable.

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

A review of five youth records found four youth were applicable for suicide prevention services. An Assessment of Suicide Risk (ASR) was completed using the required Department form for each of the four youth. A suicide risk alert was initiated for each youth and precautionary observation was authorized for each youth. A follow up ASR was completed for each youth and included all required elements. Each completed ASR determined the youth were not at risk of suicide and were placed on standard supervision. Each of the follow up ASRs were completed by a licensed mental health professional or a clinical staff under the direct supervision of a licensed mental health professional. There was documentation found of a conference held by the program director (PD) and the licensed mental health staff to reduce the level of supervision for all four youth. There was supporting documentation of the non-licensed clinical staff completing the twenty hours of required training by a licensed professional, including five co-assessments (when both the non-licensed and licensed mental health staff collectively conduct the assessments for training purposes). There was documentation of the PD establishing a review process for every serious suicide attempt or serious self-inflicted injury and a mortality review for a completed suicide. The review process included all of the required elements.

3.13 Suicide Precaution Observation Logs (Critical)	Limited 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.	

A review of five youth records found four of the youth were placed on suicide precautions. Each of the observation logs were reviewed and signed by the shift supervisor and the mental health clinical staff. Safe housing areas were not identified on three of the four reviewed observation logs. Suicide precaution observation logs were not completed on one of the four youth for the duration the youth was on suicide precautions. One of the youth was placed on precautionary observation (PO) on May 3, 2018 and did not return to the program until May 8 and 9, 2018.

The non-licensed mental health profession was unable to complete the assessment of suicide risk (ASR) at the time and the licensed mental health professional was not scheduled to come to the program on those days. The program attempted to do an ASR for the youth on May 10, 2018 but the youth did not report to the program; therefore, the ASR was completed on May 11, 2018. The program provided documentation of attempting to complete the ASR. There were no documented checks for the youth on May 8, 2018 or May 9, 2018.

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 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 reviewed plan included all of the following elements identification and assessment of youth at risk of suicide, staff training, suicide precautions, levels of supervision, referral, communication, notification, documentation, immediate staff response, and review process.

3.15 Suicide Prevention Training (Critical)	Failed 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 completed one mock suicide drill on August 27, 2018. The program were missing drills from each quarter for the period of January, March, April and June 2018. Four staff were selected for suicide prevention training and one of the selected staff received a minimum of six hours annual training on suicide prevention and implementation of suicide precautions. Two of the selected staff received five hours of suicide prevention training and one staff received three hours. All trainings were documented in the Department's Learning Management System (Skill Pro). The program maintains two suicide response kits. Staff interviews indicated the suicide response kits are kept in the bus which is used for youth transportation and in the community safety specialist's office near the first aid kit. Five staff interviews indicated if a youth expresses suicidal thoughts, staff will notify supervisor and place the youth on constant sight and sound supervision, notify the youth's parent/guardian, notify mental health staff, and document supervision.

Standard 4: Medical Services

Overview

All youth admitted to AMIkids Tallahassee are screened for health-related conditions. AMIkids does not administer or store medication on site. The program uses their episodic care, first aid, and emergency care plan in case of an emergency to enable the program to facilitate an appropriate response.

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.	

A review of five youth records found each youth was screened at the time of admission to determine if the youth had a condition requiring medical care while in the program using the Department's Facility Entry Physical Health Screening (FFPHS) form. The screening includes a review of the most recent health discharge summary. There was documentation staff made all attempts to contact each youth's parent/guardian about concerns or questions regarding each youth's medical conditions.

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 concerning medication verifications upon entry into the program. Upon admission to the day treatment program, all youth are interviewed about their current medication regimen. None of the selected five youth were currently taking medications. According to the program's policy, the program does not provide medications to youth.

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 defining staff training and the procedures for medication delivery. An interview with the executive director and four staff members revealed the program does not administer medication to youth. Five youth were interviewed and all five youth stated they were not currently taking medications.

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

The program has a written policy and procedures in place for the storing of medication. An interview with the executive director revealed the program does not store medications at the facility.

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

The program has a written policy and procedures in place defining how the program will facilitate an appropriate response to urgent or an emergency situation. All emergency equipment to include first aid kits, suicide response kits, and other required tools are in designated areas, the program bus and the community safety specialist office. These kits are monitored monthly by the community safety specialist and replenished as needed. The program does not have an Automated External Defibrillator (AED). A review of the drills revealed the program conducted one medical drill on August 10, 2018 and the drill included cardiopulmonary resuscitation (CPR) and AED demonstration. There were no mock emergency medical and mock suicide drills from each quarter for the period of January, March, April and June 2018. A review of the episodic care log, internal incidents reports and the logbook revealed the program did not have any instances of first aid or emergency care since the last annual compliance review.

Program Name: AMIkids Tallahassee
Provider Name: AMIkids, Inc.
Location: Leon County / Circuit 2
Review Date(s): November 27-29, 2018

MQI Program Code: 1237
Contract Number: P2107
Number of Beds: NA
Lead Reviewer Code: 145

Overall Rating Summary

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

Limited Ratings	Failed Ratings
3.07 Treatment and Discharge Planning	3.15 Suicide Prevention Training*
3.13 Suicide Precaution Observation Logs*	
4.05 Episodic/Emergency Services	