



Florida Network of Youth and Family Services Quality Improvement Program Report

Review of Crosswinds

on 02/04/2015

CINS/FINS Rating Profile

Standard 1: Management Accountability

1.01 Background Screening	Satisfactory
1.02 Provision of an Abuse Free Environment	Satisfactory
1.03 Incident Reporting	Satisfactory
1.04 Training Requirements	Satisfactory
1.05 Analyzing and Reporting Information	Satisfactory

Percent of indicators rated Satisfactory: 100.00%
 Percent of indicators rated Limited: 0.00%
 Percent of indicators rated Failed: 0.00%

Standard 3: Shelter Care

3.01 Shelter Environment	Satisfactory
3.02 Program Orientation	Satisfactory
3.03 Youth Room Assignment	Satisfactory
3.04 Log Books	Limited
3.05 Behavior Management Strategies	Satisfactory
3.06 Staffing and Youth Supervision	Satisfactory
3.07 Special Populations	Satisfactory

Percent of indicators rated Satisfactory: 85.71%
 Percent of indicators rated Limited: 14.29%
 Percent of indicators rated Failed: 0.00%

Standard 2: Intervention and Case Management

2.01 Screening and Intake	Satisfactory
2.02 Needs Assessment	Satisfactory
2.03 Case/Service Plan	Satisfactory
2.04 Case Management and Service Delivery	Satisfactory
2.05 Counseling Services	Satisfactory
2.06 Adjudication/Petition Process	Satisfactory
2.07 Youth Records	Satisfactory

Percent of indicators rated Satisfactory: 100.00%
 Percent of indicators rated Limited: 0.00%
 Percent of indicators rated Failed: 0.00%

Standard 4: Mental Health/Health Services

4.01 Healthcare Admission Screening	Satisfactory
4.02 Suicide Prevention	Satisfactory
4.03 Medications	Satisfactory
4.04 Medical/Mental Health Alert Process	Satisfactory
4.05 Episodic/Emergency Care	Satisfactory

Percent of indicators rated Satisfactory: 100.00%
 Percent of indicators rated Limited: 0.00%
 Percent of indicators rated Failed: 0.00%

Overall Rating Summary

Percent of indicators rated Satisfactory: 95.83%
 Percent of indicators rated Limited: 4.17%
 Percent of indicators rated Failed: 0.00%

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; limited, unintentional, and/or non-systemic exceptions that do not result in reduced or substandard service delivery; or exceptions with corrective action already applied and demonstrated.
Limited Compliance	Exceptions to the requirements of the indicator that result in the interruption of service delivery, and 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

Members

- Marcia Tavares, Lead Reviewer, Forefront LLC
- Larry Barnhill, Statewide QA Director, Lutheran Services Florida
- Kelly Barnett, Residential Supervisor, CHS WaveCREST



Quality Improvement Review

Crosswinds - 02/04/2015

Lead Reviewer: Marcia Tavares

Martha Fitzpatrick, Clinical Program Supervisor, CHS Osceola

Heather Prince, Director of Adolescent Services, BEACH House

Persons Interviewed

- | | | |
|--|--------------------------|-------------------------|
| <input checked="" type="checkbox"/> Program Director | 1 Case Managers | 0 Maintenance Personnel |
| <input type="checkbox"/> DJJ Monitor | 1 Clinical Staff | 2 Program Supervisors |
| <input checked="" type="checkbox"/> DHA or designee | 0 Food Service Personnel | 0 Other |
| <input type="checkbox"/> DMHA or designee | 0 Health Care Staff | |

Documents Reviewed

- | | | |
|---|--|---|
| <input type="checkbox"/> Accreditation Reports | <input checked="" type="checkbox"/> Fire Prevention Plan | <input type="checkbox"/> Vehicle Inspection Reports |
| <input checked="" type="checkbox"/> Affidavit of Good Moral Character | <input checked="" type="checkbox"/> Grievance Process/Records | <input type="checkbox"/> Visitation Logs |
| <input checked="" type="checkbox"/> CCC Reports | <input type="checkbox"/> Key Control Log | <input checked="" type="checkbox"/> Youth Handbook |
| <input type="checkbox"/> Confinement Reports | <input checked="" type="checkbox"/> Logbooks | 3 Health Records |
| <input checked="" type="checkbox"/> Continuity of Operation Plan | <input checked="" type="checkbox"/> Medical and Mental Health Alerts | 3 MH/SA Records |
| <input type="checkbox"/> Contract Monitoring Reports | <input type="checkbox"/> PAR Reports | 15 Personnel Records |
| <input type="checkbox"/> Contract Scope of Services | <input checked="" type="checkbox"/> Precautionary Observation Logs | 11 Training Records/CORE |
| <input checked="" type="checkbox"/> Egress Plans | <input checked="" type="checkbox"/> Program Schedules | 2 Youth Records (Closed) |
| <input type="checkbox"/> Escape Notification/Logs | <input type="checkbox"/> Sick Call Logs | 7 Youth Records (Open) |
| <input type="checkbox"/> Exposure Control Plan | <input checked="" type="checkbox"/> Supplemental Contracts | 0 Other |
| <input checked="" type="checkbox"/> Fire Drill Log | <input checked="" type="checkbox"/> Table of Organization | |
| <input checked="" type="checkbox"/> Fire Inspection Report | <input type="checkbox"/> Telephone Logs | |

Surveys

- | | | |
|---------|---------------------|---------|
| 3 Youth | 3 Direct Care Staff | 0 Other |
|---------|---------------------|---------|

Observations During Review

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

Comments

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

Rating Narrative

Strengths and Innovative Approaches

Rating Narrative

Crosswinds Youth Services, Inc. (Crosswinds) contracts with the Department of Juvenile Justice through the Florida Network of Youth and Family Services, Inc. to provide a range of supportive services targeted to youth under 18 years of age who are most at risk, including those who have run away, are truant, and/or beyond parental control in Brevard County. Services are offered onsite in the short-term residential shelter as well as community-based at the facility, in the youth's school, or in their homes. The program is located at 1407 Dixon Boulevard in Cocoa, Florida. Since its accreditation in 2007 by the Council on Accreditation (COA), Crosswinds has maintained re-accreditation and is currently accredited through May 31, 2015.

Current programs also include transitional housing and skills training for young adults 16 to 21 as they work on becoming self-sufficient, street outreach for homeless youth to help get them off the streets, counseling to reunite and strengthen families, help for youth aging out of the foster care system, and intervention for young offenders.

In January 2014, Crosswinds Youth Services received a \$10,000 grant from the Bank of America Charitable Foundation, Inc. in support of emergency shelter services. The grant was awarded as part of the Bank of America Charitable Foundation's national program supporting nonprofits that address immediate critical needs, such as hunger relief and shelter, as well as longer-term solutions that promote financial wellness through access to benefits and resources.

Crosswinds is particularly proud of its collaboration with local law enforcement that created the Brevard Civil Citation initiative. This initiative gives youths with minor offenses a second chance by offering them an alternative to arrest.

An Outreach position funded through a new contract allows the provider to hire a Street Outreach staff, Jesse Jordan, who has tenure in the field. Mr. Jordan also conducts several supplemental services to youth in the shelter such as art and recreational activities to engage youth, enhance program services, and foster a good relationship during the youth's stay.

The provider has taken the initiative to provide training for staff to receive Certification as Behavioral Technicians. More than 5 staff had successfully completed the training. At the time of the onsite visit, the agency's Medicaid Provider status was awaiting approval from one entity; however, the program is able to bill Medicaid for services.

The PAWS Program continues to be available to children in the shelter. This successful initiative pairs youth in Crosswinds' programs who need educational and emotional support with certified Crosswinds' therapy dogs for reading and other enrichment activities.

In lieu of a Golf Tournament this past year, the agency hosted a different fundraising event called Mystery Safari that raised \$50,000 for CYS. During the onsite visit, the provider was also preparing for their 16th Annual Duck Race. This event has traditionally garnered support from the media, volunteers, and sponsors and has always been a huge success.

Standard 1: Management Accountability

Overview

Narrative

Crosswinds operates both the Robert E. Lehton Children's Shelter (residential) and non-residential CINS/FINS Program in Brevard County. The CINS/FINS program has a management team that is comprised of a Chief Operating Officer (COO), a Counseling Program Coordinator, and a Shelter Manager. The COO oversees the activities of both the residential and the non-residential CINS/FINS Program. Program staff includes: five Counselors (3 Non-residential and 2 Residential), one Lead Youth Care worker, and twenty Youth Care Workers. At the time of the review, the program had three vacant fulltime Youth Care positions.

Crosswinds Youth Services participates with the National Safe Place Program, a network of voluntary community sites where youth in need of help can go for safe refuge and monitors more than 60 Safe Place sites throughout Brevard County. Outreach services, such as making presentations to interested parties or groups, attending community and provider meetings, participating in community events, and distributing informational cards and brochures, are provided by all Crosswinds staff.

The program has an Annual Training Plan for all staff and orientation training is provided to new hires. Employees receive ongoing training from the program's local providers and the Florida Network. Each employee has a separate training file that contains a training plan and supporting documentation for training received.

Crosswinds maintains valuable interagency agreements with several agencies that ensure a continuum of services for the youth and families. The program has a strong outreach component, including a Street Outreach Program, with participation of all program staff and emphasis on designated target areas.

The Department of Children and Families has licensed Crosswinds Youth Shelter as a Residential Child Caring Agency for 28 beds, effective February 17, 2014 through February 17, 2015.

1.01 Background Screening

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy and procedures in place that address the background screening of all employees and volunteers. The provider's policy reviewed onsite requires all Department employees, contracted providers, and volunteers as well as anyone else with direct and unsupervised access to youth to successfully complete a Live Scan background check prior to an offer of employment or provision of service within the program. In addition to the DJJ Background Screening Unit (BSU), the provider also screens new hires through the Department of Children and Families, Brevard County Sheriff's Department, Brevard County Clerk of the Courts (E-Fax service), and IntelliCorp for additional criminal history search.

A total of fifteen personnel files were reviewed for eight new hires, three five-year re-screened employees, and four volunteers. All of the new hires were screened and received eligible screening results prior to their hire dates. Similarly, the three staff who were eligible for their 5-year re-screenings were re-screened prior to their 5-year anniversary dates and a copy of the screening results provided evidence of the re-screening. No staff arrests during the review period were reported to the reviewer upon inquiry.

The program has utilized volunteer services of four interns who successfully met the criteria for background screening. The DJJ background screening was conducted prior to the start date for each volunteer.

As required, the provider completed its Annual Affidavit of Compliance with Good Moral Character Standards on January 14, 2015 prior to the January 31st deadline. A copy of the email submission was reviewed and verified that it was submitted the above date.

No exceptions were noted at the time of the onsite visit.

1.02 Provision of an Abuse Free Environment

Satisfactory

Limited

Failed

Rating Narrative

The program has a policy and procedures in place that address all elements of the indicator and include procedures for: 1) enforcing a code of conduct regarding staff's behavioral expectations, 2) mandating and enforcing the reporting of all allegations/suspected abuse to the abuse

hotline, and 3) requiring management to take immediate actions to address incidents of physical and/or psychological abuse or staff's failure to adhere to the agency's behavioral policy.

The program communicates information regarding the code of conduct via its personnel policies and procedures which is given to new staff upon hire and an acknowledgement of receipt is signed by staff and maintained in their personnel file. The program also has two separate, detailed policies and procedures regarding Abuse Reporting by Client and Abuse Reporting by Staff. Staff's responsibility and protocols for reporting child abuse are clearly outlined in the procedures. Upon hire, new staff is also required to read a pamphlet entitled "A Professional's Guide to Child Abuse and Neglect in Florida".

Evidence of staff reporting abuse to the hotline was reviewed using the program's Abuse Reporting Documentation maintained in a binder. During the six month review period, a total of nine (9) calls were made to the Abuse Hotline and documented on the program's Confirmation of Verbal Report of Abuse, Neglect or Exploitation. None of the allegations reported were made against the staff or the program.

In practice, the Abuse Hotline telephone numbers were observed to be visibly posted throughout the facility and is reviewed with youth and parents during admission. Each youth also receive a Resident Manual that includes information about client rights, the grievance process, and behavioral expectations.

A total of eleven grievances filed during the past six months were reviewed. In one of the grievances, staff denied the youth's allegation that staff pushed him/her. In a few other grievances, the same staff was cited for denying youth breakfast, fussing with youth about eating yogurt instead of fruits, and teasing or "egging on" youth. All of the grievances reviewed were addressed by the Shelter Manager and satisfactory resolutions were acknowledged by the youth.

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1.03 Incident Reporting

Satisfactory

Limited

Failed

Rating Narrative

The program has established a written policy and procedure for Incident Reporting that requires compliance with the Florida Department of Juvenile Justice (DJJ) Central Communications Center (CCC) requirements. Specifically, the policy requires incidents to be reported to the CCC as soon as possible, and no later than two hours of the incident/gaining knowledge of the incident.

The program maintains documentation about incidents in binders. During the reporting period, five incidents met the criteria for reporting to CCC. The incidents involved two arrests of youth for possession of marijuana, youth illness/injury requiring offsite medical treatment (2), and sexual contact between youth. Program staff called in the incidents to CCC within 2 hours of the incident and/or gaining knowledge. Follow-up documentation was documented on the Incident Reports as well as documented corrective actions taken.

One of the reportable incidents reviewed occurred on 12/25/14 at 4:37 p.m. but was not called in to CCC until 8:05 p.m. because the youth had run away from the facility and, per the report, did not report his injury to staff. Staff learned from the youth's mom that his arm was injured and he was taken to the hospital. The youth returned to the shelter with his arm in a sling at 6:58 p.m.

Several other internal incidents were documented, filed, and reviewed onsite. A review of these incidents, for the preceding six month time period, indicated that none of them were reportable to the CCC due to not meeting the criteria.

Exception:

One of the reportable incidents reviewed occurred on 12/25/14 at 4:37 p.m. but was not called in to CCC until 8:05 p.m. because the youth had run away from the facility and, per the report, did not report his injury to staff. Staff learned from the youth's mom that his arm was injured and he was taken to the hospital. The youth returned to the shelter with his arm in a sling at 6:58 p.m. Contact with mom was not documented in the program logbook or incident report to establish the time staff first learned the youth was injured and was at the hospital.

1.04 Training Requirements

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy that meets all standard requirements. The files were well organized with a check sheet and supporting documentation.

Three staff files were reviewed for ongoing training requirements. All three exceeded the required yearly hours in the standard. The majority of required trainings were completed. Two staff did not complete the Crisis Intervention Skills training and two did not complete the Suicide Prevention training.

Three staff files were reviewed for first year training requirements. All three staff still have six months to go for their year. All three staff need Suicide Prevention and Behavior Management Training. Two of the staff still need a few hours to meet the standard but have met over half the hours required.

Two non-licensed staff are trained on the suicide assessment. Each staff read the book "The Practical Art of Suicide Assessment" before the course (5 hours) and then participated in an eight hour course on how to complete the assessment. Then each staff were observed in the completion of 10 assessments which is documented in their training files. This exceeds the 20 hour requirement in both instances.

Exception:

Three staff files were reviewed for ongoing training requirements. One of the staff had not yet completed the Suicide Prevention training and had only two weeks remaining in her training year.

1.05 Analyzing and Reporting Information

Satisfactory

Limited

Failed

Rating Narrative

The program has a written policy and procedures for analyzing and reporting data for case record reviews, incidents, accidents, grievances, customer satisfaction, and outcome data. In addition, there is a comprehensive Crosswinds Youth Services Performance and Quality Improvement (PQI) Plan that includes detailed procedures to collect, review, and to report various sources of information to identify patterns and trends.

The agency delineates specific responsibilities for the Board of Directors, CEO, COO/CFO, Program Directors, Managers, Supervisors, and staff in their service areas to ensure they are meeting compliance standards. The agency-wide PQI Committee is responsible for coordinating the quarterly program reviews that include: 1) Incidents, Accidents, Grievance, and Safety; 2) Performance Measurement; 3) Case Review; 4) Direct observation; and 5) Communication with staff.

In practice, the program's PQI program includes many activities that are conducted by all staff to ensure all aspects of analyzing and reporting data are consistently implemented and documented. A peer review is completed on both residential and non-residential programs on a quarterly basis. This information is then reviewed by management. Upon completion of each record review, the review team documents the findings on the File Review Form. The form is submitted to the Program Directors and Coordinators to review and address deficiencies. Program supervisors ensure appropriate follow-up is taken by their staff and responded to in a timely manner.

The program conducts risk management reviews as part of the quarterly program review which is presented to the board of directors for review. The team reviews incident reports and grievances. These items are tracked and analyzed for PQI purposes and included in the quarterly Program Review Report. Facility Safety Reviews are performed weekly and documented on the Safety Report form.

A fiscal year of satisfaction outcomes is compiled to include percentages and remarks. Outcome data is reviewed on a quarterly basis through the QIC meeting. This discusses any shortfalls or trends that need improvement. It is also reviewed monthly through the review of the SNAPSHOT. There is a monthly review of the NETMIS data at the Presidents meeting. It discusses shortfalls and areas of improvement.

No exceptions were found at the time of the review for this indicator.

Standard 2: Intervention and Case Management

Overview

Rating Narrative

Crosswinds is contracted to provide both shelter and non-residential services for youth and their families in Brevard County. The counseling/case management program is staffed by a Program Coordinator, two Residential Counselors, and three Non-Residential Counselors. The Counselors' offices are located in an Administrative wing in the Shelter building.

The program provides centralized intake and screening twenty-four hours per day, seven days per week, and each day of the year. Trained staff are available at each program site to determine the needs of the family and youth. Upon referral, a screening for eligibility is conducted and the screening is the initiation of the assessment process. Information regarding the youths' presenting problems, living situation, etc. is collected. Upon intake into either program (residential shelter or non-residential services), a more thorough assessment is completed. After all assessments are completed, the assigned counselor develops a case plan with the family during the initial family session. If the assessment indicates the need for a referral to a more intensive or specialized service such as substance abuse or mental health treatment, the counselor makes the necessary referral for service. Crosswinds is also licensed through DCF to provide Substance Abuse Prevention Level I and Substance Abuse Intervention services. After the development of the case plan, the counselor works with the family to implement the plan. Counselors document progress towards completion of the service plan goals.

Crosswinds coordinates the Case Staffing Committee, a statutorily-mandated committee that develops a treatment plan for habitual truancy, lockout, ungovernable, and runaway youth when all other services have been exhausted or upon request from the parents/guardians. The Case Staffing Committee can also recommend the filing of a CINS Petition with the court.

2.01 Screening and Intake

Satisfactory

Limited

Failed

Rating Narrative

The agency has a written policy and procedures that address all of the key elements of this indicator. The program utilizes the NETMIS Screening Form to determine new client eligibility based on CINS/FINS criteria established in Ch.984 of the Florida Statutes. Screening forms are usually completed immediately during the first point of contact (phone or face to face). When written referrals are received (some truancy cases) they are assigned to a case manager or counselor who then ensures that a screening form is completed within 7 days.

A total of seven files were reviewed for three non-residential and four residential cases. The Screenings were completed within the 7-day timeframe in all three non-residential cases reviewed. Youth and parents consistently were provided with service options available, their rights and responsibilities, and handbook. This was noted in the progress notes and signed on an acknowledgement form in the file. Two of the three files were already involved in the CINS Court process (case staffing) and the process was explained to the third youth/ family and this was documented in the file progress notes.

Similarly, the Screenings were completed within the required timeframe in the four residential cases reviewed. Youth and parents consistently were provided with service options available, their rights and responsibilities, and handbook. This was noted in the file with signed and initialed acknowledgement forms.

No exceptions were noted.

2.02 Needs Assessment

Satisfactory

Limited

Failed

Rating Narrative

The agency has a written policy and procedure that address all of the key elements of this indicator. Needs Assessments are completed by the assigned counselor or case manager within required time frames for residential (72 hours) and non-residential cases (2-3 sessions).

All three Needs Assessments for the non-residential files reviewed were completed within two face to face contacts with youth and parent. The Needs Assessments were consistently completed by Master or Licensed staff and signed off by supervisor. Two of these files had an elevated risk of suicide identified. In both cases, the youth were evaluated by a Licensed Mental Health staff that same day.

Four Residential files were reviewed. The Needs Assessments reviewed in all four files were initiated within 72 hours of youth intake. Each were completed by Master level staff (MSW) and signed off by supervisor. Three of the four youth were identified to be at an elevated level of risk for suicide. Each of these youth was referred for a suicide assessment completed by licensed staff by the latest the following day.

No exceptions were noted

2.03 Case/Service Plan

Satisfactory

Limited

Failed

Rating Narrative

The agency has a written policy and procedure that address all of the key elements of this indicator. The agency utilizes two different service plans for residential and non-residential cases. The service plans contain all required elements listed in the required indicator such as type, location and frequency of service, person responsible, target date for completion, completion dates and signature from all involved parties.

Three non-residential files were reviewed. Each of the three service plans were completed the same date as the second and final Needs Assessment date. Each were consistently individualized listing service type, frequency and location as well as person(s) responsible, and target dates. All needed signatures were present youth, parent, counselor/ case manager and supervisor with an initiation date. Only one of these files had been open long enough to have a 30 and a 60-day service plan review. These were completed with all signatures present youth, parent, counselor, supervisor.

Four Residential files were reviewed. One of the four youth was in the shelter less than 7 days and therefore did not have a service plan. The other three service plans reviewed were consistently implemented within the seven working days of the Needs Assessment. The service plans were individualized with needs and goals identified within the Needs Assessments. Each of the plans listed type, frequency, location, persons responsible, and target date. None of the goals were completed as of the date of the QI review. Each of the plans had youth signatures and three of the four had parent signatures. One of the files documented the review of the service plan with the parent by phone. Each plan had the counselor's and supervisor's signatures as well as an initiated date. One of the youth was on a Leave of Absence (LOA) when his thirty day review was completed by the counselor and supervisor. The plan was reviewed and signed off on by youth upon his return.

No exceptions were noted.

2.04 Case Management and Service Delivery

Satisfactory

Limited

Failed

Rating Narrative

The agency has a written policy and procedure that address all of the key elements of this indicator. The assigned counselor or case manager coordinates the delivery of services both internally at the agency and externally in the community via referrals. Referrals are evident in the majority of cases reviewed and are documented in the client's case file. Case management activities are consistently recorded and tracked in the progress notes completed by the assigned counselor/case manager.

Three non-residential files were reviewed. Each file has a case manager/counselor assigned to the case with notes documenting their implementing and monitoring of services and referrals made on youth and family behalf. Two of these cases were being monitored and reviewed by Case Staffing Committee. The services coordinated were Targeted Case Management (CHS) FSPT (Funding), BA and therapy services through outside agencies, Wrap around services, and education services/ programs (Hospital Home Bound and Florida Virtual School).

Four Residential files were reviewed. Each file had a counselor/ case manager assigned to the case with notes documenting individual, family and group therapy that was provided to youths during their shelter stay. Upon discharge, referrals were documented to services as needed. It was noted that Circle of Care was utilized for one of the cases for ongoing therapy. The shelter also uses local providers such as Changes and Empower to refer youth to at time of discharge for continued counseling for the youth and family.

No exceptions were noted.

2.05 Counseling Services

Satisfactory

Limited

Failed

Rating Narrative

The agency has a written policy and procedure that address all of the key elements of this indicator.

Three non-residential files were reviewed. Counseling/case management services were documented in the notes. Counseling services addressed coping skills and monitoring of youth behavioral improvement progress. Outside referrals were made for individual and family counseling as well to address the service plan goals identified.

Four Residential files were reviewed. Each file had a counselor assigned to the case with notes documenting individual, family and group therapy that was provided to youths during their shelter stay. There is a separate binder that also contains notes as well as youth sign in sheets for group counseling provided.

The Director of Clinical Services maintains a weekly schedule for groups to include the following Monday through Friday and sometimes weekend: Anger Management, Life Skills, Substance abuse prevention, and abstinence. Fridays are 'open' days that usually consist of social skills, self-esteem or an appropriate topic to address youth needs at that time.

There is evidence of ongoing supervisory review and sign off of case records. According to the Director of Counseling Services, supervision is conducted one hour per week with Non-residential clinicians, and two meetings a week with Residential clinicians as well as a monthly meeting with all clinical staff to discuss cases and provide input and feedback to each other.

Monthly file reviews are reportedly completed for 10% of non-residential files and 100% of residential files. Quarterly file reviews are completed by management staff for COA purposes.

No exceptions were noted.

2.06 Adjudication/Petition Process

Satisfactory

Limited

Failed

Rating Narrative

The agency has a written policy and procedure that address all of the key elements of this indicator. The Case Staffing Committee process is very active, useful, and productive in the CINS/FINS service delivery process. The committee has five standing members and additional participants may attend if requested by the agency or the family. Meetings are held twice a month at the agency site on Fridays and several cases are presented by the assigned counselor/case manager and are staffed at each meeting.

Three files were reviewed. Each of these three cases were referred to the program by the school/ education department. Notification was made to the parent with no less than 5 days prior to convening the meeting. The committee members were notified by email no less than 5 working days.

Each file consistently shows that the youth's service plan is updated at the time of the Case Staffing with new/updated service recommendations. In two files, the updated service plan with recommendations was given to the parent (Parent signed and dated the bottom that copy was given that day.) In one case, the parent and youth were mailed a letter and copy of service plan with updates and recommendations within 3 days of Case Staffing Meeting.

There is an established Case Staffing Committee with regular members that include the school system, DJJ representative, law enforcement, Crosswinds Counselor/ staff. Youth and parent are welcome to bring supportive persons with them i.e. their preacher etc. Documentation in the files and binder show regular Case Staffing Meetings.

No exceptions were noted.

2.07 Youth Records

Satisfactory

Limited

Failed

Rating Narrative

The agency has a written policy and procedure that address all of the key elements of this indicator. A review of seven client case files revealed that all files are consistently organized, divided into seven sections and marked confidential. All forms contained in the files are professionally formatted and easy to locate and read.

In the residential shelter facility, all client case files are stored securely in a file cabinet near the Shelter Manager's office behind a locked door. Access is limited to authorized staff and is primarily utilized by the assigned counselor/case manager.

In non-residential services client case files are stored in a locked, secure file room with access limited to the assigned counselors/case

managers and authorized staff. All files are marked confidential and consistently formatted and organized with cover sheets for each section designating which form can be found in each section.

No exceptions were noted.

Standard 3: Shelter Care

Overview

Rating Narrative

Crosswinds operates its residential program, the Robert E. Lehton Children's Shelter, which was built in 2002 and is located in Cocoa, Florida. The shelter provides emergency residential care, 24 hours a day, 7 days a week, for youth under the age of 18 years. The facility is licensed by DCF for twenty-eight beds and provides residential services to youth in the Department of Juvenile Justice (DJJ) CINS/FINS program and youth from the Department of Children and Families (DCF). Residents are provided with a wide range of supportive services such as individual and group counseling, life and social skills training, educational and cultural activities, recreational and community service, youth development/leadership activities, transportation, and linkages to community programs. At the time of the quality improvement review, the shelter was providing services to eighteen (18) DJJ youth, including three Domestic Violence Respite youth.

The shelter has a large day room, dining room, kitchen, and separate male and female dormitories. In addition, there is a privilege room located in a loft area that is utilized for indoor recreation activities, watching television, playing board and video games. Youth must earn a minimum of 10,000 points to use the privilege room. The sleeping rooms each house two youth, with an individual bed, bed coverings and pillows.

The shelter has a fully functional kitchen. However, due to loss of funding, the program had to eliminate the Cook position and now contracts with a meal service called Sharing Center that prepares the dinner meal only. Youth care staff prepares breakfast and lunch in the kitchen for youth. Per the COO, their current menu is approved by DCF.

The shelter does have a current operating permit posted, and the county health department conducts inspections. The youth are screened at intake for special dietary needs, and this information is posted in the kitchen.

The youth care workers are responsible for conducting all admission related services for the youth, including orientation and tour of the shelter, and for conducting day-to-day activities with the youth. The youth care workers also distribute prescribed and over-the-counter medications, and administer first aid when needed. A utility knife, wire cutters, sharps and medications are stored in a locked cabinet in the staff office located in the dormitory area. First aid kits are located in the staff office, dayroom, kitchen, and vehicles.

The youth admitted to the program are screened using the Florida Network's Management Information System (NETMIS) Youth Screening Form, the CINS/FINS Intake Form, and a brief FAM (Family) General Scale. If a youth answers "yes" to any of the six questions pertaining to suicide risk on the CINS/FINS Intake form or if the staff member's observations of the youth's behavior would indicate any area of concern, an Assessment of Suicide Risk (ASR) is completed. The ASR is completed by either licensed professional or a non-licensed counselor under the direct supervision of the LCSW. A medical and mental health alert system is in place and the shelter staff that distributes medication have been trained in the distribution of medication.

3.01 Shelter Environment

Satisfactory

Limited

Failed

Rating Narrative

The agency has a written policy and procedure that addresses all of the key elements of the indicator. The following documents were reviewed:

- Fire inspection report was provided by program dated 01/23/2015. Four violations were noted on the inspection dated 01/23/2015. The inspector conducted a second inspection on 01/28/2015 and all the violations had been corrected.
- Successful Hood Inspection conducted 11/18/2014
- Annual Alarm Inspection 12/05/2014
- Health Department Inspection 01/27/2015- no violations
- License for a child caring agency from DCF expires 2/17/15

The staff identifies maintenance needs, documents, and pass on to the shelter manager who does his own maintenance inspection. The Shelter Manager completes a Maintenance/Repair Order and the repairs are completed by the maintenance company used by the Agency. While on site the Reviewer observed the maintenance company completing repairs.

The Review Team toured the facility with the Shelter Manager. The facility was clean and neat. The bedrooms were neat and the furniture was in good repair for the most part. The shelters boy's dorm bathrooms were clean and in good repair; however, the girl's bathroom showers need to be cleaned out of rags, bottle caps and rappers. On the tour graffiti was observed in the following areas laundry room wall, day room on the furniture and boys dorm room #6. There was no evidence of insect infestation. Fire and emergency drills were conducted one on each shift per month.

A board hangs in the kitchen that displays clients with special food needs and food allergy. The pantry was well stocked with food. The kitchen

was well maintained. A menu was posted in the kitchen area signed by a dietitian on 10/08/2014 however the shelter is no longer participates in the school lunch program. The meals are brought in by the Sharing Center however the current menu is not being followed.

Chemicals are kept in a locked room with MSDS sheets for each chemical and signed in and out. The chemical log inventory was up to date and accurate. Cameras, motion sensors and alarms were throughout the facility. Maps of the location were throughout the facility. Abuse hotline number was posted throughout the facility with client's rights and responsibilities. The program has two knives for life which are secured in a locked control office.

The program has three vans used to transport clients. A general safety inspection of the agency's vehicles revealed that they were all in good working order with fire extinguishers and first aid kits. Each set of van keys has a flash light/ seat belt cutter/window punch attached.

Exceptions:

Graffiti was observed in several areas of the shelter. The current menu posted in the kitchen does not match the Dinner meals prepared by the Sharing Center. The approved menu should reflect what the youth are actually eating on a daily basis based on recommendations from a licensed Dietician for optimal nutrition. Staff preparing meals are not trained for handling/preparing food.

Exceptions:

Graffiti was observed in several areas of the shelter. The current menu posted in the kitchen does not match the Dinner meals prepared by the Sharing Center. The approved menu should reflect what the youth are actually eating on a daily basis based on recommendations from a licensed Dietician for optimal nutrition. Staff preparing meals are not trained for handling/preparing food.

3.02 Program Orientation

Satisfactory

Limited

Failed

Rating Narrative

The agency has a written policy and procedure that addresses all of the key elements of the indicator. At admission each youth is given a handbook that explains behavior management, contraband, visitation, phone rules and daily scheduling. The orientation checklist is initialed by both youth and staff. The form is also signed by both youth and staff.

Three files were reviewed and all three files had the shelter orientation form with each topic initialed by youth and staff. All three checklists were signed by staff and youth. The orientation form contains all of the required elements of the standard. There was receipt of handbook in all three youth files.

No exception found in indicator.

3.03 Youth Room Assignment

Satisfactory

Limited

Failed

Rating Narrative

The agency has a written policy and procedure that addresses all of the key elements of the indicator.

The program has an alert system in place with color codes: Yellow – suicide, Red – Medication/Medical, Green – Allergy, Blue –sight and Sound, Orange- Mental Health, Purple-Physical Aggression and Black-Staff Secure.

Upon admission to shelter, youth are interviewed by shelter staff to determine the most appropriate sleeping arrangements. An alert is entered into the shelter's alert system when a youth is admitted with risks factors such as suicide, mental health issues, substance abuse, health problems or security risk. The program utilizes the CINS/FINS Intake Assessment Form to collect the information that determines youth room assignment and alerts.

Three youth files were reviewed. All three files were in compliance with the program's policy and meeting standard. All the files contained completed Intake Assessment forms with the room assignment completed with numbers and letters.

Reviewer found no exception to this indicator.

3.04 Log Books

Satisfactory

Limited

Failed

Rating Narrative

The agency has a written policy and procedure that addresses all of the key elements of the indicator.

Important information is highlighted in different colors outlined in the policy as follows:

Blue - intake

Pink - discharge

Yellow - medical

Green - self release

Orange - important information

Lavender - Transitional Living

Staff follows the color key consistently. There is evidence of date, time, staff names, youth names, and information on activities. The staff signs every entry and they are legibly written. The shelter manager and counselors review the main logbook weekly in most cases; however, the girl's logbook has no supervisory reviews documented. The logbook errors are not corrected per standard but were written over and scribbles were observed throughout the logbooks.

Exceptions were found on indicator 3.04 regarding supervisory reviews in that they are not being conducted in the girl's logbook used to document supervision of the female clients in their dormitory, only in the main logbook. Also, there were several instances where logbook errors are not corrected per the standard consistently throughout the logbooks reviewed.

3.05 Behavior Management Strategies

Satisfactory

Limited

Failed

Rating Narrative

The agency has a written policy and procedure that addresses all of the key elements of the indicator.

The program utilizes a Behavioral Model based on the Boy's Town System. The program utilizes rewards/incentives to encourage participation. Direct care staff and the Shelter Manager are trained in BM techniques. The program has a detailed written description of the behavioral management strategies (BMS) being utilized by the program. The shelter Manager was interviewed regarding the use of BMS.

Per the Shelter Manager, youth can earn up to 10,000 points which is given at the end of the day for completing specific assigned tasks. The points are added up on the point card and clients who earn up to 10,000 points a day get the privileges for that week – outing, going in the privilege room, extra phone time, special deserts and computers. If the youth has over 10,000 a day the youth can spend points in the point store. The program manager holds staff accountable on a regular basis and provides feedback of their use of rewards and consequences.

No exception was found.

3.06 Staffing and Youth Supervision

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy in place that meets all requirements of the standard. The program consistently maintains the minimum staffing ratios as required by the standard. The overnight shifts consistently exceed the standard by having a minimum of three staff per overnight shift.

The program maintains at least one staff on duty of the same gender of the youth on all shifts including the overnight shift. The staff schedule is posted in the staff office and is visible for all staff. There is a holdover rotation that is posted on the staff door and is maintained on a weekly basis.

The agency has 20 functioning cameras that have a backup for 30 days. Staff documents observation checks by documenting in the log book and on the observation log. The observation log is recorded in 30 minute increments and the staff are putting the location of the youth in that timeframe.

Exception:

Upon review of the log book, observations during sleep time is not consistently written in 15 minute timeframes as required. Several overnight shifts were found to be documenting in 30 minute time frames.

3.07 Special Populations

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy in place that meets all requirements of the standard. This agency has assigned bed days and therefore does not need approval for Domestic Violence Placements. Several of the youth have come either straight from court or they were on site for screening and came immediately into shelter rather than being screened by the JAC.

This reviewer reviewed three files. None of the files exceeded 14 day placements. All case plans for the DV youth had case plans that focused on anger management. All of the other services are consistent with the general CINS/FINS program requirements as evidenced by the documents in the file.

No exceptions.

Standard 4: Mental Health/Health Services

Overview

Rating Narrative

Crosswinds Youth Shelter has specific procedures related to the admission, interviewing and room assignment of youth to ensure the safety and appropriate supervision of youth admitted in the program. Upon admission, program staff will interview youth. An initial assessment occurs to determine the most appropriate room assignment, given the youth's needs and issues, the current population at the facility, physical space available and staff's assessment of the youth's ability to function effectively within program rules and expectations. Staff conducting the initial interview and assessment considers the youth's physical characteristics, maturity level, history including gang or criminal involvement, potential for aggression, and apparent emotional or mental health issues. Based on this information, the youth is assigned a bed which can change after further assessment. Room assignment is documented on the CINS/FINS Intake Assessment on page 2.

Staff on duty at the time of admission immediately identifies youth who are admitted with special needs and risks, such as risk of suicide, mental health, substance abuse, physical health, or security risk factors, etc. The Licensed Clinical Professional and Program Manager are notified immediately if risks and/alerts are present and recommendations regarding placement and supervision are provided to the direct care staff. This information is documented on Alert System Form that is maintained in a binder and is accessible to all staff.

Youth admitted to the shelter with prescribed or over the counter medication will surrender those medication to staff during admission. Medications are stored in a double locked medication cabinet and topical and/or injectable medications are stored separately from oral medication. Refrigeration is available for medication requiring cool storage. The program has a list of staff who are authorized to distribute medication ensures that an approved staff is scheduled on each shift. Medication records are maintained for each youth and stored in a MDR Binder.

4.01 Healthcare Admission Screening

Satisfactory

Limited

Failed

Rating Narrative

A written policy is in place. The procedures follow the guidelines of the agency's policy and procedures and the Florida Network Policy and Procedures Standards. The program performs a preliminary physical health screening for each youth at the time of admission to the shelter.

Two (2) currently open files and (1) one closed file was reviewed. In each case, the Healthcare Admission Screenings were completed at the initial intake process during the youth's admission. The forms included current medications, existing (and chronic) medical conditions, allergies, recent injuries or illnesses, presence of pain or other physical distress, observation for evidence of illness, tattoos, injury, physical distress, difficulty moving, etc., observation for presence of scars, tattoos, or other skin markings.

Of the three (3) cases, one (1) youth had extensive tattoos. In addition, one youth was on medication, two had allergies, and one had a recent illness. To date, none of the youth required follow-up of medical appointments.

4.02 Suicide Prevention

Satisfactory

Limited

Failed

Rating Narrative

The program has a written policy in place. The plan clearly delineates staff positions, duties, supervisory roles, involvement of licensed professionals, documentation protocols, notification procedures and referral systems in connection with suicide prevention and response. The procedures follow the guidelines of the agency's policy and procedures and the Florida Network Policy and Procedure Manual.

Two currently open files and one closed file was reviewed. In each case the suicide risk screening was completed during the initial intake and screening process. The screening result was reviewed and signed by the supervisor and documented in the youth's case file. Youth were placed on sight and sound supervision until assessed by a licensed professional or non-licensed under the supervision of the licensed professional. All youth were placed on the appropriate level of supervision based on the results of the suicide risk assessment. Supervision level was not changed/reduced until a licensed professional, or a non-professional under the supervision of a licensed professional, completed a further assessment or baker act.

Of the (3) three files, none of the youth were baker acted and all were removed by a licensed professional after another assessment was completed and the risk was low.

4.03 Medications

Satisfactory

Limited

Failed

Rating Narrative

The program has a written policy in place. The written procedures address the safe and secure storage, access, inventory, disposal and administration/distribution of medications in accordance with the DJJ Health Services Manual. The program's procedures include: storage of medications, oral medications that require refrigeration, narcotics and controlled medications, staff designated to distribute medication, perpetual inventory, over the counter medication, and medication distribution log.

All medications were stored in a separate, secure area behind two locks which is inaccessible to youth. Oral medications are stored separately from injectable and topical medications. There is a secure refrigeration unit for the storage of medication requiring refrigeration, but there was none on site. Narcotics and controlled medications are stored behind two locks, one lock on file cabinet and one on the storage box. Shift-to-shift counts are conducted and documented for controlled substances. Perpetual inventory with running balances are maintained of the controlled substances. There are designated staff who are the only staff delineated in writing who have access to secured medication, with limited access to controlled substances.

Syringes and sharps are secured; however, there were no syringes and no clients requiring the use of syringes. Syringes and sharps are counted at on a daily basis and there is documentation of these inventories.

Over the counter medications are counted daily and there is documentation of these inventories. A perpetual inventory is maintained.

All medication records contain the following information, youth's name, youth's date of birth, allergies and medication side effects and or precautions, with one exception. Each record had a picture of the youth attached to the record. Staff and Youth initials were documented in the record, staff full printed name, signature and title of each staff member who initial a dosage and full written name and signature of youth receiving medication.

Three open files were reviewed. Exceptions were found in these files. In one file there was a medication documentation error. The count remained the same after the medication was distributed. In another file, side effects were missing and dosage was entered in its place. Also, the parent's printed name on the delivery form was missing. In one file on the medication transfer and disposition form was missing the signature of the person accepting the medication. In one file the designated place for a signature was only initialed.

4.04 Medical/Mental Health Alert Process

Satisfactory

Limited

Failed

Rating Narrative

The program has a written policy in place. The program follows written procedures that ensure information concerning a youth's medical condition, physical restriction, allergies, common side effects of prescribed medications, food and medication contradiction and other pertinent treatment information is communicated to all staff through there alert system. Suicide risk alerts and mental health alerts are utilized to inform staff of youth suicide risk or mental health related needs. Color coded dots are used to designate medical/mental health alerts and are put on each file. There is also an alert board in the control area accessible to staff only.

Three open files were reviewed and each youth had either a Medical or Mental Health issue. All three files had the appropriate colored dot that designated the alert placed on the youth's file front cover. The color coding alerts is as follows: Red-Medication; Yellow-Suicide; Orange-Mental Health; Green-Allergies; Blue-Sight & Sound; Purple-Physical Aggression/Behavioral; Black-Staff Secure. All staff were informed and aware of what each color coded dot represented.

4.05 Episodic/Emergency Care

Satisfactory

Limited

Failed

Rating Narrative

The program has a written policy. The agency has multiple written procedures that address all of the key elements of this indicator including the following: On-Site First Aid and Emergency Care; first Aid Kits, Mental Health and Substance Abuse Emergency; Episodic/Emergency Medical and Dental Care.

The program's procedures include, obtaining off-site emergency services, parental notification requirements, incident reporting to the CCC and

Florida Network, and development and implementation of a daily log and, upon youth return to shelter, verification of receipt of medical clearance, discharge instructions and follow-up care. The three files reviewed did not warrant off-site emergency services.