Florida Network of Youth and Family Services Quality Improvement Program Report

Review of Crosswinds

on 02/17/2016

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
1.06 Client Transportation	Limited
1.07 Outreach Services	No rating

Percent of indicators rated Satisfactory:83.33%
Percent of indicators rated Limited:16.67%
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/Petitiion 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 3: Shelter Care	
3.01 Shelter Environment	Satisfactory
3.02 Program Orientation	Satisfactory
3.03 Youth Room Assignment	Satisfactory
3.04 Log Books	Satisfactory
3.05 Behavior Management Strategies	Satisfactory
3.06 Staffing and Youth Supervision	Limited
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 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:92.00%
Percent of indicators rated Limited:8.00%
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, Consultant - Forefront LLC

Terri Buckley, COO, Family Resources

Paul Hatto, Assistant Program Director, Stewart Marchman Act

Janet Valdez, Program Supervisor, Children's Home Society Osceola

Bonita Williams, QI Monitor, Department of Juvenile Justice

Persons Interviewed

- [x] Program Director
- [ ] DJJ Monitor
- [ ] DHA or designee
- [ ] DMHA or designee

0 Case Managers
3 Clinical Staff
0 Food Service Personnel
0 Health Care Staff

0 Maintenance Personnel
2 Program Supervisors
1 Other

Documents Reviewed

- [ ] Accreditation Reports
- [x] Affidavit of Good Moral Character
- [x] CCC Reports
- [ ] Confinement Reports
- [x] Continuity of Operation Plan
- [ ] Contract Monitoring Reports
- [ ] Contract Scope of Services
- [x] Egress Plans
- [ ] Escape Notification/Logs
- [ ] Exposure Control Plan
- [x] Fire Drill Log
- [x] Fire Inspection Report
- [x] Fire Prevention Plan
- [x] Grievance Process/Records
- [ ] Key Control Log
- [x] Logbooks
- [x] Medical and Mental Health Alerts
- [ ] PAR Reports
- [x] Precautionary Observation Logs
- [x] Program Schedules
- [ ] Sick Call Logs
- [x] Supplemental Contracts
- [x] Table of Organization
- [ ] Telephone Logs
- [ ] Vehicle Inspection Reports
- [ ] Visitation Logs
- [x] Youth Handbook

3 Health Records
3 MH/SA Records
10 Personnel Records
8 Training Records/CORE
2 Youth Records (Closed)
4 Youth Records (Open)
0 Other

Surveys

4 Youth | 3 Direct Care Staff | 4 Other

Observations During Review

- [ ] Intake
- [x] Program Activities
- [ ] Recreation
- [x] Searches
- [x] Security Video Tapes
- [ ] Medical Clinic
- [ ] Medication Administration
- [x] Posting of Abuse Hotline
- [ ] Tool Inventory and Storage
- [ ] Toxic Item Inventory and Storage
- [ ] Discharge
- [ ] Treatment Team Meetings
- [ ] Social Skill Modeling by Staff
- [x] Staff Interactions with Youth
- [ ] Staff Supervision of Youth
- [x] Facility and Grounds
- [x] First Aid Kit(s)
- [ ] Group
- [ ] Meals
- [ ] Youth Movement and Counts

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 in February 2015, effective through May 2019.

Crosswinds provides a wide range of programs and services for young people and their families. In addition to CINS/FINS, other programs 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, family counseling to reunite and strengthen families, help for youth aging out of the foster care system, and intervention for young offenders.

According to the agency's 2015 Annual Report, Crosswinds Youth Services has been successful in providing the following services to the community and for its funders:

- In partnership with JAC, over 1,175 youth were referred to the Civil Citation program
- Crosswinds responded to 1,322 requests for crisis counseling, information, and referral
- Youth spent 7,003 nights and over 18,000 meals were served in the shelter
- 1,843 youth were served through residential and community based services and 2,009 through outreach

There has been an increase in mental health and substances abuse problems among youth. As a result, Crosswinds continues to work with community agencies to address these issues through Brevard Care and its collaboration with the Sheriff's office. The program has also experienced a reduction in referrals to CINS/FINS and has increased its visits to schools to speak with Guidance Counselors, working with the local Sheriff, and utilizing other agency programs.

In the past year, Crosswinds implemented the Why Try training for staff beginning with Management and Counselors and continuing the training to include all Direct Care staff. The program is currently a designated Why Try Site.

Crosswinds is particularly proud of its accomplishments as follows:

- The quality and longevity of staff has resonated in the various monitoring conducted
- A recent complimentary report from a major Federal Government DHHS contract monitoring
- COA reaccreditation in February 2015
- Community support from Sea Port Canaveral (donation of furniture in the shelter) and Boeing, Girl's Scouts, and Banks
- Addition of new Board members
- The success of its inaugural Clue at the Zoo Fundraiser and continued success with the annual Duck Race

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 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.

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 eighteen 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, 2016 through February 17, 2017.

1.01 Background Screening

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy and procedures in place to ensure Department of Juvenile Justice (DJJ) Level 2 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 DJJ background screening 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 DRS Medical drug screening.

A total of ten personnel files were reviewed for six new hire, one five-year re-screened employee, and three volunteers. All of the new hires were screened and received eligible screening results prior to their hire dates. Similarly, the one staff who was eligible for the 5-year re-screening was re-screened prior to the5-year anniversary date and a copy of the screening result was provided evidence of the re-screening. No staff arrests during the review period were reported to the reviewer upon inquiry.

The program utilized the volunteer services of three interns during the review period who successfully met the criteria for background screening. The DJJ background screenings were 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 8, 2016 prior to the January 31st deadline. A copy of the email submission was reviewed and verified.

No exceptions noted for this indicator as of the date of the QI review.

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, 3) implementation of a responsive grievance process; and 4) 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 detailed policies and procedures regarding Abuse Reporting by Client, Abuse Reporting by Staff, and Grievances. 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, staff made a total of nine (9) calls to the Abuse Hotline which were 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. Per the Shelter Coordinator, management did not have to discipline staff for any incidents of abuse, neglect, intimidation, use of profanity, or excessive use of force.

In practice, the Abuse Hotline telephone numbers were observed to be visibly posted throughout the facility in the shelter lobby, above the staff desk, in the resident handbook, and on the control room windows in the dormitory areas. Abuse reporting is also reviewed with youth and parents during admission. Each youth also receives a Resident Manual that includes information about client rights, the grievance process, and behavioral expectations.

Grievance procedures are included in the Resident Handbook as well as posted on a board in the lobby and wall adjacent to the common area. The grievance box and forms are accessible to youth and are located on by the staff desk. Per the provider's policy, Direct Care Workers shall not handle the complaint/grievance document unless assistance is required by the youth. A total of two 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. The two grievances were addressed by management and satisfactory resolutions were acknowledged by the youth.

The four youth surveyed stated they knew about the abuse hotline and location of the telephone number. Three of the four youth indicated that they felt safe in the shelter and two of the four said they have not heard adults in the program use profanity are they are respectful when talking to youth.

The three staff surveyed said they have never witnessed another staff prohibit youth from calling the abuse hotline and have never heard another staff threaten youth or use profanity toward youth.

Exception

One of the four youths surveyed stated s/he was stopped/delayed in making a call to the abuse hotline. Two of the youths also stated that adults in the program were disrespectful and have used profanity when talking to youth. One youth indicated that s/he would feel safer if other youth in the program would stop trying to pick fights.

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, seven incidents met the criteria for reporting to CCC. The incidents involved two cases of battery (one youth on youth and one staff on youth), three incidents of abscond by court ordered youth, one incident of youth injury requiring offsite medical treatment, and one incident of property damage. The incidents were reported to CCC within 2 hours of the incident and/or gaining knowledge for six of the seven incidents. Follow-up documentation was documented on the Incident Reports as well as documented corrective actions taken.

Exception

One of the reportable incidents reviewed occurred on 12/28/15 at 11:39 a.m. but was not called in to CCC until 1:41pm, outside of the two hour timeframe.

The CCC calls made for three of the incidents reviewed were not documented in the program log as required by QI and the agency's operating procedure for Incident Reporting.

1.04 Training Requirements

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

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

Three staff files were reviewed for first year training requirements. One of the three staff still has three months to complete the first year and one has one month. All three staff completed Orientation training and the majority of core topics required including Suicide Prevention, CINS/FINS Core, Mental Health/Substance Abuse, Title IVE, and CPR/First Aid. It was observed that none of the staff had received Behavior Management or Crisis Intervention/Self Defense training. Staff has time to complete the Crisis Intervention/Self Defense training and the Behavior Management was rescheduled due to the QI review. All three staff exceeded the 80 hours of training required annually for first year staff.

Four in-service staff files were reviewed for ongoing training requirements. All four exceeded the 40 hours required yearly in the indicator. All of the mandatory topics required were completed.

One non-licensed staff was trained for Assessment of Suicide Risk as required. The 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. Additionally, the staff was observed in the completion of assessments which is documented in their training files. This exceeds the 20 hour requirement.

1.05 Analyzing and Reporting Information

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a Performance and Quality Improvement (PQI) Plan that addresses Quality Improvement Initiatives to include the following components:

• Quarterly monitoring

• Case record review

• Outcome measurement

• Consumer satisfaction/feedback

• Corrective action

• Information systems

• Organizational planning

Case Record Reviews

The PQI Plan indicates that Crosswinds conducts case record reviews for all programs to review required documentation elements. Quarterly case record review reports may be completed by peers. The following procedures are included in the PQI plan for case record reviews:

1. The PQI Committee maintains a file review schedule.
2. On a quarterly basis, the team reviews a sample of randomly selected open and recently closed cases for each program.
3. Files are reviewed for the presence and quality of required documents.
4. Following the review, the review team records the findings on the File Review form.
5. The form is submitted to the Directors, Program Coordinators and Managers.
6. The Directors and Program Coordinators and Managers review the information on the File Review form with programmatic staff in the appropriate monthly staff meeting.
7. If corrective action is necessary, the action will be recorded on the PQI Quality Improvement Action form, and the PQI process will be activated.

Peer review forms were reviewed for the months of September 2015 to current which revealed the following: reviews are conducted on a monthly basis by the counseling staff or interns and then reviewed by the Clinical Director as evidenced by his initials in the upper right hand corner of the form. A review of the peer review binder confirms the following number of reviews were conducted for shelter files: 5 – February 2016; 4 – January 2016; 3- December 2015; 8-November 2015; 11 – October 2015; and 11 – September 2015 (although this month's forms are not dated, they are filed in chronological order according to the Clinical Director).

A review of the peer review binder confirms the following number of reviews was conducted for non-residential files: 17 – February 2016; 3-January 2016; 4- December 2015; 14-November 2015; 4-October 2015; and 7-September 2015.

Quarterly review of incidents, accidents and grievances.

Crosswind's PQI plan outlines a quarterly review process, which includes a review of incident and grievance logs that document any behavior management incidents and use of any restrictive interventions. The following provides details for each category:

Grievances

According to the PQI plan: 1) Directors, Program Coordinators and Managers report to the COO on client grievances; 2) The COO receives and reviews information on grievances; 3) Grievance data is included in the annual Program Review Report; and 4) The President/CEO and PQI Committee also review client grievances through the quarterly Program Review Report.

Grievances are kept in binder in CFO's office after review conducted by Shelter Manager and COO. However, information pertaining to grievances is not included in an annual report, nor in the Monthly Snap Shot report, formerly called the Program Review Report. CFO could not find any documentation of analysis that is shared with staff regarding grievances.

Incidents & Accidents

According to the PQI Plan: 1) The COO receives and reviews information on incidents on a regular basis to oversee that timely action occurs; 2) Incident/accident data is compiled monthly in the Incident Reporting Database; 3) Incident/accident data is included in the Program Review Report; 4) At least quarterly, Crosswinds conducts a review of incidents/accidents to include restrictive intervention techniques and all instances where a person served was a danger to him/herself or others; and 5) The President/CEO and PQI Committee also review incidents through the Program Review Report. Incident data is entered into the Access Data Base that was created specifically for incident reporting. It is very comprehensive and includes many data elements. Reports are generated based on need. Incident data is included in the Snap Shot report. Accidents are considered an incident and as such an internal document would be completed and entered into the data base described above.

Annual review of customer satisfaction data

According to the PQI Plan, satisfaction surveys are given to each youth and parent/guardian during the last face-to-face contact between staff and client. If they are unable to meet during the last scheduled meeting, the survey is mailed with a stamped, pre-addressed envelope. The Finance Office is responsible for entering data from the surveys into an internal Microsoft Access database, or NetMIS as required by contract, on an ongoing basis. Interview conducted with CFO, verified procedure and practice is consistent with the policy. However, the agency currently uses NetMIS to enter satisfaction surveys and no longer use the Access Database.

According to the PQI Plan, Crosswinds mails a confidential survey a minimum of an annual basis to measure satisfaction among collaborative partners and other community stakeholders. Data from surveys is aggregated and reported to the President/CEO and, as appropriate, to the Board and relevant staff.

The CFO provided a report indicating the results of the community/client satisfaction survey, where 58 surveys were sent to community members, 112 to consumers, 2 to contractors, 15 to governing body, 36 to personnel and 10 to supervisors and managers. A total of 57 surveys were received. Results are not yet available.

Annual review of outcome data

According to the PQI Plan, key areas measured include:

• Functional status, e.g., an improvement in a youth's behavior, academic performance, or in family functioning

• Health status

• Welfare and safety

• Permanency of life situation

• Other quality of life measures as determined by the organization

Crosswinds produces a Monthly Snap Shot Report by program to include intakes, numbers served, age at referral, gender, race, budget information and outcomes reported by the Florida Network. This is discussed during the President's Meeting (CEO, COO and CFO) held on a weekly basis as evidenced by meeting notes/minutes. The COO discusses this data during staff meetings on a monthly basis. On a quarterly basis, the data is reviewed with management and supervisors as confirmed by meeting minutes. Program specific information and outcome data is reported to the board during quarterly board meetings as evidenced by Board Meeting minutes.

Monthly review of NetMIS data reports

The NetMIS snapshot information is discussed at the weekly President's meetings, monthly staff meetings and quarterly QIC meetings with managers and supervisors as evidenced by meeting minutes.

Quarterly review of Knowledge Portal

Interview with Shelter Manager indicates that reports are pulled for inventory, side effects and purpose of medications from Lexi Pro on a weekly basis. However, quarterly reports from the Knowledge Portal or Pyxis Med-Station have not yet been utilized.

Exceptions

Incident/Accident procedures and practices are not consistent with current PQI plan in terms of terminology and process.

Grievances are kept in binder in CFO's office after review is conducted by Shelter Manager and COO. However, information pertaining to grievances is not included in an annual report, nor in the Monthly Snap Shot report, formerly called the Program Review Report. CFO could not find documentation of analysis that is shared with staff regarding grievances.

Quarterly reports from the Knowledge Portal or Pyxis Med-Station have not yet been utilized by the Crosswinds shelter.

1.06 Client Transportation

☐ Satisfactory ☒ Limited ☐ Failed

Rating Narrative

The agency has implemented a Transportation policy that includes drivers approved by administrative personnel; however, the policy is missing some of the requirements of the indicator as listed in the exceptions below. Policy section 5-12 meets the requirements of Florida Network QI Standard 1, indicator 1.06 with the following: 1) Crosswinds staff are permitted to use their personal vehicle to transport youth only when a Crosswinds' van is unavailable or the parent/guardian is unable to transport the youth; and, 2) Staff will not transport clients unless they are approved by their Program Coordinator, Shelter Manager, Director of Counseling Services or COO. A review of the vehicle log book indicated 10 single transports from January 14th to February 16th.

Staff will have an approved 3rd party person present in the vehicle when transporting youth. An approved 3rd party person can be another staff, a volunteer, an intern or a youth. To transport youth, staff must adhere to the following:

• Have a valid Florida Class E Safe Driver's License

• The vehicle has a valid State of Florida registration

• Have valid insurance coverage as required by the State of Florida

• Have reliable and properly maintained transportation

• Ensure passengers are utilizing age appropriate vehicle passenger restraint systems

• Are covered under Crosswinds' insurance policy

Staff will document each trip in company vehicles using the log located in each vehicle. Drivers will annotate their name or initials, date and time, mileage, number of passengers, and purpose and destination of travel.

An interview conducted with the Shelter Manager indicated that the program has 3 vans; staff have not utilized personal vehicles for at least 6 months, if not longer. A review of each van's vehicle log book contains all of the above documentation requirements.

The agency's transportation policy prohibits transporting a client without maintaining at least one other passenger in the vehicle during the trip, which could be an approved volunteer, intern, agency staff or other youth.

Exceptions

The agency's transportation policy does not include exceptions in the event that a 3rd party is NOT present in the vehicle while transporting. It also does not indicate that in the event that a 3rd party cannot be obtained for transport, the agency's supervisor or managerial personnel consider the client's history, evaluation and recent behavior is considered prior to a single youth transport. The program does not have a procedure in place where the Shelter Manager is made aware of a single transport and consent is documented accordingly prior to the transport. A review of the vehicle log book indicated 10 single transports from January 14th to February 16th.

The Transportation policy indicates at a minimum annually, Crosswinds validates the driver's licenses and driving records of employees who transport youth. CFO conducts driver's license verification once per year when the agency's insurance policies are due. The agency has a part time volunteer that was the former HR assistant who performs random verifications one other time per staff per year to ensure licenses are valid and insurance is active. A review of 3 staff personnel files indicates the following: on employee's driver's license expired Jan 15, 2016; two other employees do not have evidence of active insurance in their files. CFO ran DMV checks on all 3 staff at the time of the review and all were found to be valid. CFO stated that if the individual did not have active insurance, the report would have indicated "not valid".

1.07 Outreach Services

☐ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

Crosswinds Youth Services is funded by the Department of Health and Human Services for a Street Outreach program. Its Street Outreach program targets the needs of runaway, homeless and at-risk youth by providing services on the streets of Brevard County. A mobile outreach unit provides tangible items, such as food, clothing and hygiene products to street youth. The program also distributes literature and referral information for other needed services, including medical clinics, food banks, GED assistance, and job training programs.

The Street Outreach Team at Crosswinds is out four or more nights a week talking to youth about shelter options; educating youth about community resources; and handing out snacks, clothes and hygiene packs. Youth can receive these services without questions. The Street Outreach team focuses on building rapport and trust with youth. Members of the Street Outreach staff are also available for community presentations on homeless youth.

In addition to Street Outreach, designated program staff participates at some of the DJJ Board/Circuit 18 Council meetings. The meetings are scheduled sporadically and the provider was not present at all of the meetings held.

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.

During the past year, Crosswinds implemented the WhyTry program which was created to provide simple, hands-on solutions for dropout prevention, violence prevention, truancy reduction, and increased academic success. The WhyTry curriculum utilizes a series of ten visual analogies that teach important life skills (e.g. decisions have consequences; dealing with peer pressure; obeying laws and rules; plugging in to support systems).The provider is a designated Why Try site and to date has trained its management and counseling staff and is in the process of completing the training with all of the Direct Care staff.

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. Centralized intake services are available and accessible twenty-four hours a day, seven days a week, throughout the year.

The procedures indicate the youth and parent/guardian will receive in writing during the intake the following information: 1) Available Service Option, 2) Rights and responsibilities of youth and parents/guardian, 3) parent brochure, 4) Information about the possible actions that could occur through involvement with CINS/FINS services (i.e. Case staffing committee, CINS petition, CINS adjudication), and 5) Grievance procedures.

A total of six files were reviewed for three non-residential and three residential cases. The Screenings were completed within the 7-day timeframe in all six cases reviewed. Youth and parents consistently were provided with service options available, their rights and responsibilities, and handbook.

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. The program has a process for the Needs Assessment to be completed. The procedures contain the elements required by the Florida Network. For Residential youth, the assessment is required to be initiated within 72 hours of admission, if the youth is in shelter care; or updated if the most recent Needs Assessment is over six (6) months old. The assessment must be completed within 2-3 face-to-face contacts following the initial intake or updated if the most recent Needs Assessment is over six (6) months old, if the youth is receiving non-residential services. The procedures also require the Needs Assessment to be completed by a Bachelor's or Master's level degree and should be reviewed and signed by a clinical supervisor in a timely manner. If a suicide risk assessment is required, it must be reviewed by a licensed clinical supervisor or written by licensed clinical staff.

Two of the three Needs Assessments for the non-residential files reviewed were completed within two face to face contacts with youth and parent and one case had an updated Needs Assessment as the most recent was over 6 months old. The Needs Assessments were consistently completed by Master or Licensed staff and signed off by supervisor. None of these files had

an elevated risk of suicide identified.

Three Residential files were reviewed. Two of the three Needs Assessments for the residential files reviewed were completed within 72-hours of admission and one case had an updated Needs Assessment as the most recent was over 6 months old. 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. The procedures indicate the case manager/counselor shall review the service plan every 30 calendar days for the first 3 months the youth is in CINS/FINS program and every six months thereafter, and that case records document all efforts to engage and include the family/guardian or designated others in the service plan.

The program has a process for a case/service planning in that it is developed with the youth and the family within seven (7) working days following the completion of the needs assessment. The Case Plan is developed based on the information gathered during the initial screening, intake and assessment.

Two of the three non-residential files were eligible for case plan implementation and one was in progress. Each of the two service plans were completed timely. Each was 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 the two files had a 30 and a 60-day service plan review completed with all signatures present youth, parent, counselor, supervisor.

Two of the three Residential files were eligible for case plan implementation and one of the three youth was in the shelter less than 7 days and therefore did not have a service plan. The other two 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. One of the plans indicated some of the goals were completed as of the date of the QI review. Each of the plans had the youths' signatures as well as signatures of the counselor and supervisor; one of the two had parent signatures. Case plan reviews for the two eligible residential cases reviewed were not due yet.

Exception

One of the two applicable non-residential files reviewed was not reviewed for progress every 30 days for the first three months as required. The date of the service plan was 7/20/2015 but reviews were completed on 8/31, 9/30 and 11/3/2015. Staff was informed of this issue and immediately implemented a corrective action plan.

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. A review of the six case files demonstrated that the case managers provided the following services when the need for these services were indicated as needed:

- Followed the youth's case and ensue delivery of services through direct provision or referral
- Established referral needs and coordinating referrals to services based on the ongoing assessment of the youth/family's problem and needs
- Coordinated service plan implementation
- Provided supportive services to the family
- Recommend and pursued judicial intervention in selected cases
- Accompanied youth and parents to court hearing and related appointments, if applicable
- Made referral for additional services, if needed
- Monitored out-of home placements
- Continued case monitoring and review including court orders , and
- Provided case termination and follow-up (closed cases were not reviewed).

No exceptions were noted.

2.05 Counseling Services

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a written policy and procedures in place to ensure that youth and families receive counseling services in accordance with the needs identified during the assessment process.

Three (3) residential and three (3) non-residential files were reviewed. The Youth and families were offered counseling services in accordance with the youth's case/service plan. The case/service plan addressed the needs identified during the assessment process, including issues related to substance abuse, mental health and suicide risks. The program maintained chronological notes on the youth's progress.

The program maintains individual case files on all youth and adhere to all laws regarding confidentiality. The program also maintains an on-going internal process that ensures clinical review of case records, youth management, and staff performance regarding CINS/FINS. Found in the "Clinical Meetings Binder". Supervisors reviewed the case records as evidenced by signed needs assessments, treatment plans or as per the counselor's documentations at the 30/60/90 review dates.

The shelter offers individual/family counseling services. Counselors meet with the youth as planned and if the youth or caregiver were not available, or canceled, documentation in the progress notes were noted.

The program provides different types of groups; Health/Abstinence, Anger Management, Substance Abuse, Life Skills, and open discussion groups.

Quality Improvement Youth Survey Tabulation of 4 youth showed that 3 of the 4 youth reported having a counselor. The three youth stated yes to their counselors asking them what they wanted to do while in the shelter and also reported knowing what goals they were currently working on.

Exception

Groups are not consistent with the requirements as they are not being held a minimum of five days per week.

2.06 Adjudication/Petitiion 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 procedures establish a referral to the case staffing committee as needed to address the problems and needs of the youth/family when 1) The family or youth does not participate in the services selected, 2) The family or youth is not in agreement with the services or treatment offered, or 3) The Department of Juvenile Justice or Crosswinds CINS/FINS Case Manager receives a written request from the parent /guarding or any other member of the committee.

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. Exceptions to this schedule are made within seven (7) days (excluding weekends and holidays) after the receipt of a written request from a parent/guardian.

Three files were reviewed. Each of these three cases was 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 one file, the updated service plan with recommendations was given to the parent (Parent signed and dated the bottom that copy was given that day).

Exception

Two of the three cases were not consistent with providing evidence that the Parent/guardian were provided with a copy of the recommendations and reasons behind the recommendations within 7 days of the case staffing meeting.

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. The program has a process for maintaining youth records. The policy and procedures offer the youth with an individual file, chronological notes on the youth's progress, and provides ongoing internal case review/case monitoring that ensures clinical review of the case records.

All 6 records were marked confidential. All records are kept in a secure room or locked in a file cabinet, marked confidential and all records are maintained in a neat and orderly manner. 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 identified.

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 program, 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) CIN/FINS program and youth from the Department of Children and Families (DCF). Residents can utilize a wide range of support services. These include individual and group counseling, life and social skills training, educational and cultural activities, recreational and community service, transportation and they are able to link up to all community programs. At the time of the quality review, the shelter was providing services to fifteen (15) youth. Of these youth ten (10) are DCF youth and five (5) are CINS/FINS youth.

The shelter has large day room, dining room, kitchen, separate male and female living area and a laundry area. There is a privilege room located in the loft area that is used for indoor recreational activities, watching television, play board and video games. Youth must earn a minimum of 10,000 points to use this room. The sleeping rooms each house two (2) youth. Each youth has an individual bed, bed coverings and pillows.

The shelter has a fully functional kitchen. The shelter still contracts with the Sharing Center that provides the diner meal only. Youth care staff prepares breakfast and lunch in the kitchen for the youth. The shelter does have a current operating permit with the County Health Department conducting inspections. The youth are screened at intake for special dietary needs and this information is posted in the kitchen. At the time of the shelter tour two (2) youth were listed on the alert board in the kitchen for food allergies.

The youth care workers are responsible for conducting admissions and related services for the youth, including the program orientation and facility tour and for conducting the day-to-day activities. The youth are admitted to the program are screened using the Florida Network's NetMis Youth Screening Form and Florida Network Youth and Family Services CIN/FINS Intake Form. Designated youth care workers also distribute prescribed and over-the-counter medications, and administer first aid when needed. A knife for life and sharps 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 program implemented the use of the Pyxis 4000 Medication Cart for medication storage, management, and distribution in 2015. 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.

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.

3.01 Shelter Envonment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

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

The shelter is licensed for 28 youth. At the time of the tour the shelter had 15 total youth in care: five (5) CINS/FINS and ten (10) DCF youth. The boy’s side of shelter has ten (10) rooms with two (2) beds per room for a total of twenty (20) available beds and they are separate from the girl’s. The boy’s side has its own control room for monitoring the youth during sleeping hours. The girl’s side has four (4) rooms with two beds per room for a total of eight (8). There is room for an additional four (4) beds in the great room that is a large open area next to the girl’s rooms.

The following documents were reviewed:

- DCF License for child caring facility effective through 2/17/2017
- Health Department Inspection dated 1/19/2016 – one violation #13 for Hand Sink/Hot Water to ensure provision of soap and paper towels for hand wash sink in the kitchen This issue was corrected on site at the time of inspection
- Fire Inspection Report citing no violations, dated 2/2/2016
- Fire System and Hood inspection completed 11/11/2015
- Fire Sprinkler inspection completed 2/9/2016

The shelter team toured the facility with clinical director. The facility was clean and neat. The bedrooms were neat and the furniture was in good repair. Some of the older wooden furniture had been replaced with new furniture. The bathrooms were clean and free of rags, debris etc. There was minimal evidence of graffiti in one of the bedrooms and staff removes it when possible as soon as possible. Each youth has an individual bed with clean, covered mattress, pillow, blanket etc. There is appropriate light for activities performed.

There was no evidence of insect infestation. Staff had reported that they had one of the rooms treated for bed bugs by Terminix recently. The grounds were well maintained.

In addition to and/or supplemental to the indicator a review of Major Programmatic Requirements were reviewed. A thorough disaster plan was in place and a current plan was submitted to the Florida Network on 2/26/2015. A current plan is not due to be submitted until March 2016.

Next, facility Fire, Safety Standards were reviewed. This section includes: a) fire inspection and facility compliance, b) agency fire drills, c) mock emergency drills, d) life-for-knife, first aid kits, wire cutter, and bio-hazard waste disposal bin viewed, e) fire safety equipment inspections up to date (extinguishers, sprinklers, alarm system and kitchen hood), f) current Department of Health satisfactory inspection, g) current satisfactory food service inspection from Department of Health with menus posted and signed by Licensed Dietician annually, h) 2- cold food storage refrigerators, i) properly marked and labeled dry store/pantry area that is clean with food properly stored. Refrigerators/freezers are clean and maintained at proper temperatures.

All of these areas were reviewed and appeared to fully meet with one (1) exception. There was food that was not properly labeled. The program supervisor had this food removed at the time of inspection.

The shelter facility has 38 operational cameras. One of the vehicles had a jagged piece of metal on the rear door where a mounted tire was removed. All other areas in this section appeared to be fully met.

The final section in this area covers grievances and the daily activities schedule. The shelter has a posted grievance box that provides youth with clear, accessible and fair avenues for lodging and resolving complaints. The grievance box with the forms above it was located in the great room at the end of the staff desk. This box was also locked. The shelter had posted a daily activities schedule that offered an organized program of daily activities that included social/physical recreation, educational/study time opportunities, treatment services and a faith-based component.

Two (2) youth were interviewed as to the posted daily menu and whether what is posted is served every day. Both youth stated the menu is accurate. One stated it only changes if the service does not show up or for a last minute change. One youth stated the menu is posted in the dining room and the other youth stated it is not.

Exception

None of the staff responsible for preparing meals during the weekends when the meal service is not utilized were certified as food handlers.

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 the time of admission each youth is given a handbook that explains the behavior management system, a list of contraband items, disciplinary actions, dress code, access to medical, dental and mental health services, procedures for visitation, mail, telephone, grievance procedures, disaster preparedness, facility layout, room assignments and suicide prevention/alerts. The orientation checklist is initialed by both youth and staff. The form is also signed by both youth and staff.

This practice was validated in a review of three (3) open files. Three (3) files indicated that youth received: a comprehensive orientation and handbook (within 24 hours), disciplinary action, grievance procedures, emergency/disaster procedures, contraband rules, facility layout, room assignment, suicide prevention-alert notification, signature of youth with parent-guardian obtained, daily activities reviewed and abuse hotline number provided.

The three (3) youth files had evidence that the youth and staff signed that the youth received the Orientation Handbook and the Shelter Orientation checklist. The information is conveyed verbally and in the Orientation Handbook.

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 the color codes:

- Yellow- suicidal
- Red- medication/medical
- Green- allergy
- Blue- sight and sound
- Orange- mental health
- Purple- physical aggression
- Black- staff secure

At the time of admission to the shelter the youth are interviewed by the 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 that include: suicidal issues, mental health issues, substance abuse, health problems and security risks. The program utilizes the CINS/FINS Intake Form to collect information that determines a youth room assigned and alerts.

Three (3) youth charts were reviewed for a completed CINS/FINS Intake Form, room assignment and alerts. Two of the three had completed the CINS/FINS Intake forms. All three (3) had room assignments listed. The log book was checked for the youth being written in with room assignments and alerts. All three (3) youth were written in the logbook (logbook 12/14/2015 through 2/14/2016 was used) and had room assignments.

Upon review of the alerts, one youth had no alerts listed in log book but on the alert chart, an orange dot- mental health- was indicated. Another youth did list the alerts of medications and suicidal issues and was placed on sight and sound; however, the log book did not list mental health- orange or physical aggression- purple.

Exceptions

All three (3) files did not have all the alerts listed in the logbook at the time of intake. One youth did not have a completed CINS/FINS Intake Form and this is being used to make youth room assignments.

3.04 Log Books

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a written policy. Logbook requirements are to include: safety and security issues, brief and legibly written in ink, incidents with youth and staff involved with date, time and signature, all recording errors are struck through with a clear line with staff initial and date, supervisor reviews are conducted weekly, dated and signed with recommendations for follow up required, supervisors and all staff review the logbook for the previous two shifts, supervision and resident counts, visitation and home visits and entries are made in ink without erasures and white-out areas.

Important information is highlighted in different colors outlined in the policy and placed on a label in the front of the log book.

- Blue- intake
- Pink- discharge
- Yellow- medical
- Green self-release
- Orange- important information
- Lavender- transitional living

There is evidence of date, time, staff names, youth names and information on activities. The staff signs every entry and they are legibly written. There is evidence of the shelter manager reviewing the log book weekly. All three (3) files reviewed had been documented in the logbook at the time of intake.

Exceptions

The only exceptions are that on several logbook entries staff did not write the word "void" per their policy after making a single line through the error. Reviewer could not find evidence of log being reviewed by managers and counselors as outlined in their policy and there was inconsistent documentation for the direct care staff indicating that they have reviewed the logbook on a daily basis.

Some of the logbooks reviewed were not stamped or marked confidential.

3.05 Behavior Management Strategies

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a written policy. The agency also has a policy on Behavioral Intervention and Restrictive Intervention. These two (2) policies support the overall standard of Behavior Management Strategies (BMS). The program uses the Boy's Town System as their behavioral model. The program uses rewards/incentives to encourage participation. Some of the rewards are the XBOX 360, Cable TV time, additional phone time, and being able to go on paid outings.

The program manager was interviewed regarding the use of the Behavior Management Strategies. The shelter manager stated the 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 can earn up to 10,000 points a day get the privileges for that week: outing, going to the privilege room, extra phone time, special deserts and computers etc. If the youth has over 10,000 a day the youth can spend their points in the point privilege store. The program manager holds the staff accountable and provides feedback of their use of rewards and consequences.

The shelter manager did state they are looking into a different system for the DCF youth that are at the shelter longer than 30 days due to the system not working as well for their needs.

Two (2) youth were interviewed in regards to the BMS and one youth stated it was not fair partly because the DCF youth do not use the system. However, this youth would like to provide input if the system ever was to change. The other youth showed me her point card and was working with the BMS to earn her points and privileges and is keeping the proof to be able to go on paid outings.

Exception

Two (2) staff training files were reviewed with dates of hire as 3/2/2015 and 5/19/2015 did not have evidence of being trained on the BMS.

3.06 Staffing and Youth Supervision

☐ Satisfactory ☒ Limited ☐ Failed

Rating Narrative

The agency's policy 3-19 for staffing and youth supervision meets the requirements of awake hours 1 to 6 staff to youth ratio, and sleep hours of staff to youth ratio of 1 to 12. Staff to youth ratio for staff secure youth is 1 to 5.

Three days were randomly selected to review the program's staffing ratios. All 3 days were in compliance on all 3 shifts. Overnights shifts consistently maintain a minimum of 2 staff present with at least one staff on duty of the same gender as evidenced by a review of the staff schedules. The staff schedule is posted on the bulletin board and also placed in each staff person's mailbox. A holdover overtime rotation roster with contact numbers is also kept in the logbook. Staff can sign up on a sheet to request additional shifts.

Many discrepancies were discovered during a review of the logbook and camera footage for overnight bed checks. For example, on February 15th to 16th between 2:42 am and 3:08 am youth were observed in the privilege room and not in their rooms asleep as the logbook indicated. In addition, 15 minute bed checks were not being conducted. On January 25th to 26th, the logbook indicated that the youth were in their dorm rooms; however, 3 of the youth were observed in the dining room. In addition, no bed checks were made from 12:30 am to 2:07 am. A bed check was conducted by a different staff person than who recorded the entry in the logbook. A bed check made at 2:30 am was conducted by the staff person who made the entry. On February 16th to 17th log book entries indicate that checks were made by staff from 1:10 am to 2:45 am when in fact no bed checks were conducted.

Bed checks conducted on February 6th, 2016 matched the entries in the logbook for the male dorm. On January 31st, no check was conducted at 4:45 am as indicated in the log book. In addition, on February 6th, no bed checks were conducted at 4:00 am, 4:25 am, 4:39 am, 4:50 am or 5:01 am as indicated in the log book. Lastly, on February 15th, no bed checks were conducted at 3:30 am, 3:45 am, 4:00 am, 4:15 am or 4:30 am. There was a check completed at 4:50 am, documented in the log as 4:45 am.

Falsification of documentation regarding bed checks was found on several dates on both the male and female dorms. The CCC was contacted and report was accepted, report# 2016-00976.

3.07 Special Populations

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has policies and procedures in place that align to the QI standards and FL Network policies. 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.

Domestic Violence

Two of the three files reviewed had documentation on the screening form that the initial call was received from Detention to pick up the youth for domestic violence. The third file indicated that the mother had called the shelter indicating that the youth unlawfully struck her with a stick and caused bruising.

Two of the three youth were discharged prior to the 21st day and the 3rd youth was transitioned to a CINS youth on the 21st day. In two of the three files, the youth did not stay long enough to have a case plan created; the third one reflects anger management and communication skills.

Staff Secure

The agency has policies and procedures in place that align with the QI Standards and FL Network policies. Three staff secure youth files were reviewed. All three youth met the criteria for being admitted into the staff secure program as evidenced by appropriate court orders. The program assigns a specific staff person to monitor the youth's location and movement; documentation was found on the Location Chart and assigned staff was identified on the youth roster. The program also provided written reports to the court regarding the youth's progress.

No youth meeting the criteria for Probation Respite or Domestic Minor Sex Trafficking were served by the program during the review period and these areas were marked not applicable.

No exceptions were found for this indicator.

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 the Pyxis Med-Station 4000 Medication Cart which provides thumb print access and added security to the maintenance and distribution of prescribed medication. Topical and/or injectable medications are stored separately from oral medication. Refrigeration is available for medication requiring cool storage. The program has designated Super Users for the Med-Station and a list of approved staff who are authorized to distribute medication. Medication records are maintained for each youth and stored in a MDR Binder.

4.01 Healthcare Admission Screening

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program has written policy and procedures in place to address healthcare admission screening. The procedures follow the guidelines of the agency's policy and procedures and the Florida Network Policy and Procedures Standards. The program completes the preliminary physical health screening for each youth at the time of the admission. The screening includes but not limited to current medications, existing medical conditions, allergies, recent injuries/illnesses, presence of pay or other physical distress, observation for evidence of illness, injury distress, difficulty moving etc., and observation for presence of scars, tattoos, injuries indications of substance abuse or other skin markings.

One open case file and two closed files were reviewed. Three of the three files reviewed had documentation the Healthcare Admission Screening form was completed upon youth's admission into the program. The forms included general information, substance abuse screening, risk screening, physical health screening, and room assignment. The forms included medical conditions, allergies, medications and emergency contact. Medical referrals are located in the chronological sections of the case files.

One of the three files had documentation of a youth having an allergy. Two of the three files had observations of scars, tattoos, and/or other body markings. None of the three files required follow up of medical appointments at the time of the review.

4.02 Suicide Prevention

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program has written policy and procedures in place to address suicide prevention. The policy and procedures has detailed guidelines for suicide prevention and response. The policy complies with the procedures outlined in the Florida Network's Policy and Procedure Manual for CINS/FINS.

One open and two closed files were reviewed for this indicator. All three files had documentation the suicide screening process occurred at admission. This form is signed by the supervisor upon completion of the screening and is in the case files. The youth are assessed by a licensed professional or non-licensed under the direct supervision of the licensed professional.

Two of the three files revealed the youth was placed on sight and sound supervision. Two of the three files had documentation of thirty minute checks and signed observation logs. The level of supervision did not change until the licensed professional or non-licensed under the direct supervision of the licensed professional. In the two applicable files, the youth was removed from supervision after another assessment was completed and the risk is low. None of the files reviewed had documentation baker act was not initiated. Upon discontinuation/termination of precautionary observation the program updates the alert board, log book, verbally and/or email and the front page of the youth files was also updated.

4.03 Medications

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program has written policy and procedures in place to address medications. The program complies with policy and procedures addressing the safe and secure storage, access, inventory, disposal, and administration/distribution of medications in accordance with the DJJ Health Services Manual. All medications, syringes and sharps are to be secured and stored appropriately. The policy and procedures include staff responsibility and parent notifications.

The program has a secured location for syringes and sharps; however, at the time of the review the program did not have any youth requiring syringes for medication.

The program stores all medications in a separate, secure area, which is inaccessible to youth. The program has a Pyxis Med-Station 4000 for storing medications including narcotics and

controlled medications which is stored behind two locks. Nine staff have been trained to handle prescribed medication. Oral medications are stored separately from injectable and topical medications. Storage is clearly labeled.

The program stores medications requiring refrigeration in a secured refrigerator which is only used for the purpose of medications needing refrigeration. The refrigerator is not used for food storage. The refrigerator is secured with a pad lock and behind a secured door only accessible by staff.

A review of three open cases revealed medication records contained youth's name, date of birth, allergies, medications side effects and/or precautions, picture of the youth, staff and youth initials on records. Each reviewed file had shift to shift counts of all medications located on the bottom of each medication record for each youth, which includes staff initial and inventory. In addition, each staff member's full name, signature and title were on the medical records. The secured refrigeration unit for storing medications was not in use because there were none on site.

The program maintains documentation of over the counter medications on a weekly basis. The program keeps sharps in a locked storage area not accessible to youth. The program keeps a perpetual inventory with running balances for controlled substances which is located in the case file and the Pyxis Med-Station 4000 maintains a count.

Four youth surveys reported two staff assisted with their medications

4.04 Medical/Mental Health Alert Process

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program has a policy and procedure in place to address the medical/mental health alert process. The program ensures information concerning a youth's medical condition, physical activity restrictions, allergies, common side effects of prescribed medications, food and medication contraindication and other pertinent treatment information is communicated to all staff through an alert system. Per the program's policy staff will document conditions in the program logbook highlighted.

One open and two closed files were reviewed for this indicator. The suicide risk alerts and mental health alerts are used to inform staff of youth needs. The program has an alert board located in the control area, accessible to staff only. Color coded dots are used to designate medical and mental health alerts and are put on each file. Each youth's file is accessible to staff for review of any alerts as well as documentation in logbook. The programs policy stated all program staff must ensure that proper documentation pertaining to a youth with potential risk occurs, including shift reports, incident reports, program logs, observation reports and location charts.

Three of the three files reviewed had documentation the youth had either medical, mental health or food allergies. All three files were placed on the program's alert system. The program alert system includes concerns in regard to prescribed medications, medical and mental health conditions. The program communicates alert during shift transition, log books, alert board in a location only accessible to staff and case files. Two of the three files reviewed had documentation in the log book in regard to medical and/or mental health alerts. The staff is a part of the intake process so therefore, staff are placing the youth on the program alert systems. All three files reviewed had documentation identifying alerts with the color coded dot system. All changes to the youth's alert system status are promptly reflected on the alert system board, the log book and the youth's case file.

Four staff surveyed reported they are informed of the youth's medical and mental health alerts during shift meetings, log books, youth files and alert forms.

Exception

One of the three files reviewed, did not have notation in the program's logbook in regard to youth's medication and youth being placed on sight and sound supervision.

4.05 Episodic/Emergency Care

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program has a policy and procedure in placed to address episodic/emergency care. The policy includes examples of episodic care, parent notifications and staff responsibilities.

The program maintains an emergency medical/dental care log located in the control room for easy access for staff documentation and review. The program has provisions of emergency medical and dental care to include obtaining off-site emergency services, parental notification and daily log.

The program maintains a binder with a log of emergency medical and dental care provided. The log includes the youth's name, date, time, physical compliant, parental contact, treatment facility, and outcome. The knives for life are kept in a locked storage in the control room and in the program vehicles. The program has five first aid kits that are located in the control room, dorms, staff desk and kitchen. The program has portable kits for the vehicles. Three of three files reviewed had documentation of emergency medical procedures.

One of three youth surveyed reported receiving very good care in the program. One of the three surveyed reported the care provided is poor. One youth did not respond to the question.

One of four staff surveyed reported the suicide response kit is located on a wall mounted. One staff reported a kit located in the vehicle. Three staff reported the kits are located in the staff station or cabinet.

Four staff were survey for how they are informed of medication side effects. The staff reported that the staff are informed of medication side effects during shift transitions, physician desk reference, census board, medical alert log and alert form in file.

Exception

According to an incident report, one youth was taken off site for emergency care due to an injury to the jaw on 12/31/15. In a review of the emergency medical/dental care log, this incident was not documented on the log.