



Florida Network of Youth and Family Services Quality Improvement Program Report

Review of Crosswinds

on 12/06/2017

CINS/FINS Rating Profile

Standard 1: Management Accountability

1.01 Background Screening of Employees/Volunteers	Satisfactory
1.02 Provision of an Abuse Free Environment	Satisfactory
1.03 Incident Reporting	Limited
1.04 Training Requirements	Satisfactory
1.05 Analyzing and Reporting Information	Satisfactory
1.06 Client Transportation	Limited
1.07 Outreach Services	Satisfactory

Percent of indicators rated Satisfactory:71.43%
Percent of indicators rated Limited:28.57%
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	Satisfactory
3.07 Special Populations	Satisfactory
3.08 Video Surveillance System	Satisfactory

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

Percent of indicators rated Satisfactory:92.59%
Percent of indicators rated Limited:7.41%
Percent of indicators rated Failed:0.00%

Rating Definitions

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

Satisfactory Compliance	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.
Not Applicable	Does not apply.

Review Team

Members

Ashley Davies, Lead Reviewer and Consultant, Forefront LLC

Venus Highsmith, Director of Youth Services, Nehemiah Educational and Economic Development

Kelly Barnett, Residential Supervisor, Children's Home Society WaveCREST

Sherri Swann, Clinical Director, Lutheran Services Florida NW (Currie House)

Kamille Payne, Regional Monitor, Department of Juvenile Justice

Persons Interviewed

- | | | |
|---|--|---|
| <input checked="" type="checkbox"/> Chief Executive Officer | <input type="checkbox"/> Executive Director | <input checked="" type="checkbox"/> Chief Operating Officer |
| <input checked="" type="checkbox"/> Chief Financial Officer | <input checked="" type="checkbox"/> Program Director | <input checked="" type="checkbox"/> Program Manager |
| <input type="checkbox"/> Program Coordinator | <input checked="" type="checkbox"/> Direct- Care Full time | <input type="checkbox"/> Direct-Care Part Time |
| <input type="checkbox"/> Direct-Care On- Call | <input type="checkbox"/> Volunteer | <input type="checkbox"/> Intern |
| <input checked="" type="checkbox"/> Clinical Director | <input checked="" type="checkbox"/> Counselor Licensed | <input checked="" type="checkbox"/> Counselor Non- Licensed |
| <input checked="" type="checkbox"/> Case Manager | <input type="checkbox"/> Advocate | <input checked="" type="checkbox"/> Human Resources |
| <input checked="" type="checkbox"/> Nurse | | |
| 1 Case Managers | 0 Maintenance Personnel | 2 Clinical Staff |
| 1 Program Supervisors | 0 Food Service Personnel | 1 Other |
| 1 Health Care Staff | | |

Documents Reviewed

- | | | |
|---|--|--|
| <input type="checkbox"/> Accreditation Reports | <input checked="" type="checkbox"/> Fire Prevention Plan | <input checked="" 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 checked="" type="checkbox"/> Key Control Log | <input checked="" type="checkbox"/> Youth Handbook |
| <input checked="" type="checkbox"/> Logbooks | <input checked="" type="checkbox"/> Fire Drill Log | 5 # Health Records |
| <input checked="" type="checkbox"/> Continuity of Operation Plan | <input checked="" type="checkbox"/> Medical and Mental Health Alerts | 5 # MH/SA Records |
| <input type="checkbox"/> Contract Monitoring Reports | <input checked="" type="checkbox"/> Table of Organization | 5 # Personnel Records |
| <input type="checkbox"/> Contract Scope of Services | <input checked="" type="checkbox"/> Precautionary Observation Logs | 7 # Training Records |
| <input checked="" type="checkbox"/> Egress Plans | <input checked="" type="checkbox"/> Program Schedules | 3 # Youth Records (Closed) |
| <input checked="" type="checkbox"/> Fire Inspection Report | <input type="checkbox"/> Telephone Logs | 5 # Youth Records (Open) |
| <input checked="" type="checkbox"/> Exposure Control Plan | <input type="checkbox"/> Supplemental Contracts | 3 # Other |

Surveys

6 Youth 5 Direct Care Staff

Observations During Review

- | | | |
|---|--|--|
| <input type="checkbox"/> Intake | <input checked="" type="checkbox"/> Posting of Abuse Hotline | <input checked="" type="checkbox"/> Staff Supervision of Youth |
| <input checked="" type="checkbox"/> Program Activities | <input type="checkbox"/> Tool Inventory and Storage | <input checked="" type="checkbox"/> Facility and Grounds |
| <input checked="" type="checkbox"/> Recreation | <input checked="" type="checkbox"/> Toxic Item Inventory and Storage | <input type="checkbox"/> First Aid Kit(s) |
| <input type="checkbox"/> Searches | <input type="checkbox"/> Discharge | <input type="checkbox"/> Group |
| <input type="checkbox"/> Security Video Tapes | <input type="checkbox"/> Treatment Team Meetings | <input checked="" type="checkbox"/> Meals |
| <input type="checkbox"/> Social Skill Modeling by Staff | <input checked="" 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 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.

Since the last quality improvement review, Crosswinds Youth Services has accomplished many things, including:

- The shelter received the Basic Center Grant this year.**
- Over \$100,000 was raised from the annual Duck Race fundraiser.**
- The agency is working with Boeing on a grant for new furniture.**
- The CEO reported that morale is better with staff. The CEO met with staff members in small groups and did focus groups with the youth, to come up with a better strategic plan to enhance programs and have effective risk management.**

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.

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 conducted 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.

1.01 Background Screening

Satisfactory

Limited

Failed

Rating Narrative

The agency has a written policy requiring all applicants, including subcontractors and volunteers, to undergo a background screening. No applicant may be hired or service provider utilized until the background screening is complete.

The agency has a written procedure to implement the background screening requirement for all new staff, volunteers, and interns. Staff must also have a new screening conducted every five years of employment. The agency must submit the background screening materials to the background screening unit. If an employee is deemed ineligible and exemption may be requested within thirty days. Any employee who is deemed ineligible that is not granted an exemption may not be hired by the agency.

The background screening consists of the Criminal History Acknowledgement Form, Request for Live Scan Screening Form, driver's license copy, fingerprint card, request for Local Law Enforcement Record Check, Crosswinds Transportation Requirements, consent for Motor Vehicle Check, Regulations for the Use of Vans (if applicable), Letters of Reference, and a \$44 payment for the completion of the background screening. The agency also requires an Annual Affidavit of Compliance With Good Moral Character Standards which must be completed annually and submitted by January 31st of each year.

The agency hired four new staff since the last annual compliance review in February 2017. All four new staff had background screenings completed by the Background Screening Unit (BSU) of the Department of Juvenile Justice (DJJ) prior to being hired. All staff were deemed eligible and did not require an exemption.

One staff member is due for a five-year rescreen on December 26th; however, the rescreening was already

completed, on September 26th, 2017. The agency submitted their Annual Affidavit of Compliance to the BSU on January 27th, 2017.

There were no exceptions to this indicator.

1.02 Provision of an Abuse Free Environment

Satisfactory

Limited

Failed

Rating Narrative

The agency has a written policy requiring the unimpeded access of youth to self-report alleged abuse. The agency also has a written policy establishing a grievance process and the youth's right to submit a grievance without fear of retaliation.

The agency has a written procedure defining unimpeded access to the Florida Abuse Hotline as allowing youth to make the decision to report allegations of abuse without obtaining permission. Asking staff permission to use the telephone is not considered impeding unless staff refuses to allow the youth to make the call. The agency must have the telephone number of the Florida Abuse Hotline posted in all living areas and readily visible to youth. The youth must acknowledge the abuse reporting procedures on the Client Rights and Responsibilities form. If staff become aware of abuse at any time, they must immediately contact the abuse hotline before reporting it to their supervisor. Staff must then complete the incident reporting procedures to document the abuse.

The agency has a written procedure outlining the grievance process and the rights youth are allowed to grieve. The process includes an informal phase, formal phase part one, and formal phase part two. Direct Care Workers are not allowed to handle grievances unless the youth has requested assistance in filling out the form.

The agency has a code of ethics that prohibits the use of physical abuse, profanity, threats, and intimidation. A review of five personnel records showed evidence that each employee signed the code of ethics. Each of the five personnel records reviewed also included a signed acknowledgement of child abuse reporting training. Staff also receive an orientation and ethics class as part of their initial training which was verified in three reviewed staff records.

During a tour of the agency shelter, postings of the Florida Abuse Hotline phone number was observed in all three living areas. Agency staff reported youth are allowed unimpeded access to call the abuse hotline and staff are offered to help them place the call if wanted. The agency maintains a record of all calls to the Abuse Hotline in the Chief Operating Officer's office. Management takes immediate action to address incidents of physical and/or psychological abuse, verbal intimidation, use of profanity, and/or excessive use of force. Youth are provided with and sign a copy of a Client Rights and Responsibilities form that is maintained in the youth file. This form outlines the client's right to call the hotline and provides the telephone number for the youth and guardian who also signs and receives a copy.

During the tour a locked grievance box was found in the commons area with grievances stocked directly above the box and accessible to youth. The Client Right's and Responsibilities form outlines the grievance process for the youth and the rights they are allowed to grieve while in the program. The agency maintains a grievance binder with all grievances and follow-up conducted in each stage of the process that the grievance progressed through. The agency utilizes an informal phase, formal phase step one, and formal phase step two. The direct care workers do not handle youth grievances unless providing assistance to the youth filling out the grievance. This was confirmed through an informal interview with management staff.

There were no exceptions to this indicator.

1.03 Incident Reporting

Satisfactory

Limited

Failed

Rating Narrative

The agency has a written policy that requires staff to follow procedures for completing external and internal incident reports to assure accurate information is disseminated and to track and document action related to incidents. The policy also requires the agency to comply with the Florida Administrative Code when reporting to the Central Communications Center (CCC).

The agency has a written procedure requiring all incidents be documented in program logs and on incident reporting forms and then reviewed and signed by the program director and Chief Operation Officer or designee. The agency must also report all reportable incidents to the CCC within the required two-hour timeframe of incident discovery.

During the last six months, the program has had one CCC incident. The CCC report was called in on October 30, 2017 within two hours of the incident being discovered. The incident was called in due to one youth requesting to press charges on another youth following a physical altercation. The Cocoa Police responded and charged the youth. An update was provided on November 1, 2017 that no injuries resulted from the incident and both youth had been transitioned out of the shelter. The CCC submitted follow-up questions to the agency which were addressed within the requested twenty-four hour timeframe. The incident was documented on the agency incident reporting forms, was reviewed and signed by the shelter manager and chief operating officer (COO), and is maintained in the program log for incident reports. The incident was also found in the electronic logbook. A review of the program logs revealed the shelter manager and COO review and sign all incident reports.

Exception:

During a review of the emergency medical/dental care log it was found there were three incidents where CINS/FINS youth were transported offsite for emergency medical care during the review period. None of the three incidents were called into the CCC. Two of the three incidents were also not found as documented in the agency logbook.

1.04 Training Requirements

Satisfactory

Limited

Failed

Rating Narrative

The agency has a written policy and procedures in place requiring staff to complete eighty hours of training within the first year and twenty-four hours each year thereafter. The mandatory trainings for first-year staff include orientation, CINS/FINS core training, Managing Aggressive Behavior, Suicide Prevention, Signs and Symptoms of Mental Health and Substance Abuse, CPR and First Aid, Behavior Management, Understanding Youth/Adolescent Development, Child Abuse Report, Confidentiality, Universal Precautions, Title IV-E procedures, Medication Distribution for Non-Licensed Staff, Fire Safety Equipment, Serving LBGQT Youth, Cultural Humility, and required Department of Juvenile Justice (DJJ)- SkillPro Learning Management System courses. Following the first year of employment staff shall complete training on fire safety equipment, crisis intervention, CPR/First Aid, and suicide prevention.

The agency maintains individual training files for each staff member. The files include an annual training plan and all relevant documentation of the training completed by each staff. Three records were reviewed for staff who have completed their first year of employment since the last annual compliance review. All three staff met the requirement for eighty hours of training. All three staff completed the required trainings

of program orientation, managing aggressive behavior through Crisis Prevention Intervention training and certification, Suicide Prevention Training, CINS/FINS Core, Signs and Symptoms of Mental Health and Substance Abuse, Behavior Management, Title IV-E Procedures, Fire Safety Equipment, CPR/First Aid certification, Ethics, Confidentiality, Child Abuse Reporting, Information Security Awareness, Trauma Informed Care, Prison Rape Elimination Act, In-Service, Medication Distribution for Non-Licensed Staff, Serving LGBTQ Youth, and Cultural Humility. All three staff records reviewed did not have documentation of Understanding Youth/Adolescent Development training.

Four staff records were reviewed for annual training beyond the first year of employment. All four staff had more than double the required number of training hours and completed the required trainings for Crisis Prevention Intervention, Suicide Prevention, and Fire Safety Equipment. Three of the four staff had updated CPR/First Aid certifications. Three of the four staff completed the Prison Rape Elimination Act training at least once in the last two years; however, the fourth staff has the remainder of the month to complete the training.

It should be noted the agency has worked to introduce additional training in Suicide Prevention and Serving LGBTQ Youth to satisfy the updated training requirements.

Exceptions:

The agency does not have documentation of the completion of Understanding Youth/Adolescent Development for new staff members. Management confirmed this is a curriculum they discontinued and will have to incorporate back into their training.

One staff member's CPR/first aid certification expired October 27th, 2017. The agency had the staff complete the training on December 7th, 2017 while the review team was on-site.

1.05 Analyzing and Reporting Information

Satisfactory

Limited

Failed

Rating Narrative

The agency has a written policy in place requiring the collection and review of several sources of information to identify patterns and trends. This information must then be shared with staff and stakeholders, strengths and weaknesses identified, and improvements implemented.

The agency has a written procedure necessitating the creation and collection of reports of aggregated data and a committee/workgroup that analyzes the data. This analysis should lead to performance improvement efforts.

The agency collects and reviews multiple sources of data throughout the year. Data is compiled in a data snapshot and in a risk management report that is shared with the advisory board. This data snapshot includes outcome and NetMIS data. This information is also reviewed by the Continuous Quality Improvement (CQI) Team at the agency which consists of all the managers who then disseminate information to their teams. The CQI team reviews all incidents, accidents, and grievances. Case records are also reviewed on a quarterly basis by the management staff. The CQI team generally meets quarterly, but have not met since August 18th, 2017; however, the agency still has the rest of the month to meet the quarterly requirement for this team. The agency also compiles and reviews customer satisfaction data, but has yet to do so for the last fiscal year 2016/2017. Data was compiled for fiscal year 2015/2016. All of the data is also reviewed for patterns and trends at the presidents' meeting that is held at least monthly with

the Chief Executive Officer, Chief Operating Officer, and Chief Financial Officer.

As part of the advisory board, presidents', and CQI meetings, strengths and weaknesses are identified and minute meetings kept. The agency has an informal process for performance improvement and often uses e-mail communication to disseminate information on improvement practices.

Exceptions:

The CQI team generally meets quarterly, but have not met since August 18th, 2017; however, the agency still has the rest of the month to meet the quarterly requirement for this team.

The agency also compiles and reviews customer satisfaction data, but has yet to do so for the last fiscal year 2016/2017.

1.06 Client Transportation

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy in place for Client Transportation that was last revised in February 2017.

Crosswinds has a policy, revised February 2017, that states that staff shall transport youth in personal vehicles only when Crosswinds van is unavailable for use of the parent/guardian is unable to transport the youth. Crosswinds staff will not transport client unless they are approved by their Program Coordinator, Shelter Manager, Director of Counseling, or Chief Operating Officer on call.

When transporting youth, staff will have an approved third party person preset in the vehicle. An approved third party person can be another staff, a volunteer, and intern, or a youth.

In the event that a 3rd party is not present in the vehicle while transporting, the Shelter Manager or designee will consider the client's history, evaluations, and recent behavior prior to single youth transport. The Shelter Manager or designee consent is documented in the log book. The staff will remain on the phone with the staff on site until client and staff have returned to the shelter.

To transport youth, staff must adhere to the following:

- Have a valid 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.

Staff should immediately inform their Supervisor of any safety or maintenance issues that may jeopardize the safety of youth.

At a minimum twice yearly, Crosswinds validates the driver's licenses and driving records of employees who transport youth.

Reviewer reviewed a sample of three employee files for their driver's license information. All three contained Live Scan results with Eligible rating on their Class E Florida Driver's license. Employment letters of direct care staff addressed that, "Your employment is contingent upon retention of your Class E Safe Driver Florida Driver's License, maintaining adequate insurance for use of your vehicle in the course of agency business, and receipt of satisfactory reference." The program conducted additional, minimal of

two, driver's license checks on staff, after hire. All three files contain proof of personal auto insurance. The program conducts annual checks on staff auto insurance. In one case, a letter was sent to an employee advising him that his insurance had expired and that he needed to send in updated proof of insurance.

Also, reviewed Daily Vehicle Inspection form. They were current through 12/5/17. Inspections are conducted by the first shift.

Observed staff transport of six youth: four girls and two boys. Two staff, one male driver and one female staff transported the youth to a nearby park. The youth transported were not in school because they were new to the program and awaiting the school system to transition their school records.

Three vans were present. All three had binders in them with van #, VIN #, and tag # on the outside. The vehicle registration was valid. The vehicle insurance is valid until October 2018. Transportation logs included the following information: Date, Destination, Driver, Beginning Mileage, Ending Mileage, Number of Passengers. Although not required by policy, one van, Van number three, has a camera. However, it was inoperable.

Exception:

A review of the van logs revealed there were twenty-two single client transports since August 2017. There was no documentation found or provided during the review to show these transports were approved by a supervisor prior to taking place.

1.07 Outreach Services

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy in place for Outreach Services that was last revised in December 2015.

Crosswinds Youth Services policy, revised December 2015, says that every effort will be made to optimize awareness of Crosswinds so that as many children and families as possible can know of these services and can benefit from them.

Every interaction or communication a member of Crosswinds' staff has with the public is considered an outreach for the organization.

Crosswinds' Chief Operating Officer will designate a lead staff member to attend local DJJ Board and Council Meetings. This person will advocate for the effective use of CINS/FINS services and update agency leadership on meeting activities. This person will also obtain meeting minutes for file and obtain a copy of attendance at meetings.

Crosswinds has a written Outreach Prevention Plan, dated March 2014, that includes public awareness and outreach activities targeting youth who are most likely to become delinquent or have issues with substance abuse or other negative behaviors.

Crosswinds Outreach efforts are outstanding.

Reviewer reviewed documentation that staff COO or designated staff regularly attend DJJ Circuit 18 Advisory Board meetings. The agendas and minutes are maintained in a binder.

Reviewed documentation of program's collaborative partners, including but not limited to: agreements with health agencies, mental health agencies, substance abuse agencies, youth shelters, homeless coalition, food bank, UCF School of Social Work- Orlando, YMCA, faith-based organizations, and a host of other community organizations.

Reviewed programs, Outreach Plan dated 2014. It is very specific in stating the program will do things such as:

- **-Provide 100 outreach presentations annually to its CIN/FINS programs.**
- **-Provide a minimum of 52 outreach presentations per year for all other Crosswinds programs.**
- **-Produce and distribute the latest Crosswinds Annual Report.**
- **-Upgrade and maintain an organizational website with specific information for youth and families.**

Reviewed documentation from September 2016 - May 2017 of the Outreach Event Forms. The program uses various means of communicating about the program including, but not limited to: presentations at banks, rotary club, tours, meetings with Family Promise organization, school board meetings, Care Fair, National Night Out, BHC Providers Meeting, Civil Citation meetings, DJJ CAB meetings, agency website, and Facebook page.

Development Director for Donations and Outreach advised that the program is promoted throughout Brevard County. The program engages many volunteers in their two big fundraisers, Duck Race and Clue at the Zoo.

Crosswinds maintains a very thorough website. The website is an excellent Outreach tool. It contains information about the program, the services, ways to get help, Board of Directors, financial audits, the latest Annual Report.

The Annual Report contains successes, thank you to their 700+ volunteers, impact of services, and funding.

There were no exceptions to 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. 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 is also licensed through DCF to provide Substance Abuse Prevention Level I and Substance Abuse Intervention services.

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

Policy and Procedure indicates services are accessible 24 hours a day, 7 days a week. During the intake to services, information on available service options, rights and responsibilities, parent brochure, information on CINS/FINS services and possible actions that could occur, as well as grievance procedures.

The NetMIS Youth Screening Form is utilized to determine client eligibility for services. Youth who are not appropriate for services are referred to appropriate agencies. The completed screening form is submitted to the Program Coordinator or designee for approval or denial of placement. Runaway and homeless youth must be admitted to shelter. If a bed is not available, an appropriate placement must be found in another licensed shelter.

All completed screening forms are kept on file with the Shelter Manager and reviewed weekly to ensure appropriate action was taken by staff completing the forms.

The CINS/FINS Intake Assessment is conducted on each youth entering the program during the face-to-face visit. The form is used to ensure the youth can be safely placed in the shelter and is not in need of immediate physical or mental health attention. If a youth scores positive on the suicide risk screening questions, the SPS is completed.

Interview with the shelter counselors explained the Needs Assessment is initiated when section B of the client file is completed. Section B includes an extensive array of screening/assessment tools such as AADIS, CINS/FINS Risk Factors, NetMIS demographics, ATOD, Anger/Violence Evaluation and suicide evals (if applicable).

For non-residential services, screenings are completed immediately upon referral by the administrative

assistant. She enters the NetMIS data and forwards them to the Non-Residential Clinical Supervisor for assignment to non-res counselors. The counselors contact the family to schedule services as soon as possible, typically the same day.

Reviewer reviewed two open and two closed residential files. All four files contained documentation supporting the practices noted in the Policies and Procedures, and included all the required elements. The shelter intake documentation is inclusive of all the elements required to meet the standard, including client rights and responsibilities, written information about service options, grievance procedures and acknowledgment from parents that they received the Parent/Guardian Brochure.

Reviewed two open and two closed non-residential files. All four files contained documentation supporting practices, noted in the Policy and Procedures, and included all the required elements. It is the practice of the non-residential counselors to provide CINS/FINS handbook along with a packet of educational materials to the youth and parents at intake. The materials provide answers to questions typical of adolescents on a variety of topics.

There were no exceptions to this indicator.

2.02 Needs Assessment

Satisfactory

Limited

Failed

Rating Narrative

The policy and procedure indicates the Needs Assessment (NA) is initiated within 72 hours of admission for youth in shelter care and is completed within two to three face-to face contacts following the initial intake or updated if the most recent NA is over six months old, for youth receiving non-res services.

The NA is conducted by a Bachelor's or Master's level professional, and is reviewed and signed by a clinical supervisor in a timely manner. If the suicide risk component is required, it must be reviewed (signed and dated) by a licensed clinical supervisor or written by a licensed clinical staff.

According to the policy and procedure, the assessment is an on-going process throughout the duration of services. The Needs Assessment is fully completed, leaving no blanks. In addition, other assessment tools utilized to determine client needs, include the Anger Evaluation, AADIS (Substance Use Evaluation), and the PAT (Prevention Assessment Tool).

All four of the residential files reviewed had the Needs Assessment initiated within 72 hours. As noted by the shelter counselors, the Needs Assessment is considered initiated when the section B assessment/screening documents are complete. Three of the four files contained fully completed Needs Assessment, for the one incomplete file, the youth was discharged after a five day stay. All assessments were completed by master's level clinicians and were signed off by the licensed supervisor. None of the Needs Assessments resulted in elevated risk of suicide or warranted a referral for a Suicide Assessment.

In addition to the Needs Assessment, the shelter files also contained Anger/Violence Evaluation and Alcohol & Drug Involvement Scales. According to the Clinical Supervisor, all shelter clients get both of these tools at intake. These tools are used to aid in the Needs Assessment process and to give the staff a heads up regarding the youth's disposition on these topics, in reference to what behaviors staff may expect in shelter.

All four of the non-residential files reviewed had the Needs Assessment completed in two to three face to face contacts. In three instances they were completed in one session. All assessments were completed by master's level clinicians and all were signed off by the licensed supervisor. None of the youth were identified as having an elevated risk of suicide upon completion of the Needs Assessment. Subsequently, none warranted further Assessment of Suicide.

The Needs Assessment addresses current and past issues affecting the youth, as well as his/her current

level of suicide risk. The signatures on the Needs Assessment denote the counselor's degree level and supervisory review.

There were no exceptions to this indicator.

2.03 Case/Service Plan

Satisfactory

Limited

Failed

Rating Narrative

Policy and Procedure reflects a Service Plan is developed with the youth and family within seven working days following completion of the Needs Assessment. It is developed based on information gathered during the screening, intake, and assessment.

Further, it is noted that the Service Plan is built on the strengths of the youth/family, and the person served is engaged in resolving the identified problems. The Service Plan includes all the required elements: Individualized needs and goals; Service type, frequency, and location; Persons responsible to complete the goals; Target dates for completion Actual completion dates; Signature of youth, parent/guardian, counselor, and supervisor; Date the plan was initiated.

There is to be a clear and logical relationship between the content of the assessment, the initial service plan and the service plan developed with the youth/family. When referrals are necessary, they are made with serious consideration of the following criteria: Need for the referral; Cost of the referral; Family/youth resources, including work schedule, childcare and transportation; Other barriers to service; Most effective means of service delivery; and Willingness of youth/family to participate.

The youth and family agree to participate by signing the plan, as well as the Counselor/ Case Manager and his/her supervisor. If the youth and/or parent/guardian are not available for signature, this shall be documented on the Service Plan. For Non-residential services, plans are reviewed every 30 days for the first three months and every six months, thereafter to assess progress or need for revision.

Seven of the eight files reviewed contained completed service plans. The one file without one was for a youth discharged after five days, who also didn't have a completed Needs Assessment. Two of three residential files reviewed did not meet the seven day time-frame for completing the Service Plan. They were complete in twelve and fourteen days following the Needs Assessment. The residential Service plan form for the files reviewed does not include a place for "Date of Initiation". During the review process, the Clinical Director made an addition to the form for future use.

All eight files reviewed were individualized and prioritized according to the Needs Assessment. The Service Plans included service type, frequency, and location, as well as the person's responsible and target dates. All eight files included the signatures of the youth, parent, counselor, and supervisor. Four of the files included timely progress updates with all required signatures. The other four files did not require an update due to timing.

One of the closed residential files did not contain the actual completion dates. The other closed residential file was for the youth discharged after five days, who did not have a completed Needs Assessment or Service Plan. Both of the closed non-residential files contained actual complete dates.

The forms used to verify the Indicator was the Crosswinds Service Plan. The form was designed to capture the required elements of Type of Service, Frequency, Location, and Person Responsible. All files reviewed included individualized goals and had the necessary signatures.

Exception:

Two of three residential files reviewed did not meet the seven day time-frame for completing the Service Plan. They were complete in twelve and fourteen days following the Needs Assessment.

2.04 Case Management and Service Delivery

Satisfactory

Limited

Failed

Rating Narrative

Policy and Procedure indicates each youth shall be assigned a Counselor/Case Manager who will follow their case and ensure service delivery of services through direct provision or referral. The Counselor/Case Manager coordinates services and referrals based upon the on-going assessment of need. The process of Case Management includes all the required elements, from establishing referral needs and coordinating referrals all the way through case termination.

The program maintains a system of treatment/service monitoring which assures cases are reviewed formally on a periodic basis. The system includes, but is not limited to: Internal Case Review by Counselors, Supervisors, and Consultants (staff directly associated with the program); Peer and Utilization Review (staff not directly associated with the program); External Case Review by Contraction Agencies; Case Conference review; Review for unsummarized notes, observations, and impressions, and other material that should be expunged at closing of the record.

All eight files reviewed indicated a counselor was assigned and that they coordinate service plan implementation with the youth and family. This was documented on the Counselor Service Record for the residential files and on the Chronological Case Notes for the non-residential files. None of the eight files contained a referral to the Case Staffing Committee. All records showed documentation in the Chronological Notes of the Counselors' efforts to engage families and provide support throughout services. These notes included phone calls, home visits, school visits, and office visits.

All four closed files reviewed contained case termination notes, found on the Discharge Summary. These notes include: Reason for Discharge; Events in Case; Services Provided; Progress of Youth/Family; Living Arranges at Discharge; Recommendation for Aftercare Services, in addition to Arrangements for Case Follow-Up. Four of the eight files contained referrals, as appropriate. The remaining files didn't warrant an outside referral. Follow ups were located for the files requiring follow-up.

The Crosswinds Service Plan was compared to the Needs Assessment and screening form to track inclusion of client issues on each form. The Service Plan and subsequent reviews, along with the Chronological Children's Service Record were reviewed to confirm the practice to monitor and support youth and families' progress and need for referrals.

There were no exceptions to this indicator.

2.05 Counseling Services

Satisfactory

Limited

Failed

Rating Narrative

The policy and procedure for Counseling Services includes all the required elements for Shelter and Non-Residential cases. Policy and Procedures indicate the shelter provides individual, family, and group counseling. Group counseling is provided a minimum of five days per week. The policy details the program's procedure selecting topics and capturing each youth's performance on a group member's performance sheet. At the end of the week, the individual performance sheets are to be placed in the resident's case file. This policy was last updated August 2014.

For residential clients, at the beginning of each group, the residents are asked to sign in on the Group Sign-in Roster. After the group, the facilitator immediately completes each individual group members' performance sheet. At the end of the week, the individual performance sheets are to be placed in the residents' case file.

All eight files reviewed showed efforts to engage the families in services in accordance with their case plans. The files reflected individual and family chronological notes. The youth's presenting problems were consistently addressed in the Needs Assessments, Service Plans, and Service Plan reviews. Chronological notes indicated client activities.

The documents used to review this Indicator include the policy and procedure to determine process; the Group Counseling log to determine frequency of groups; the Needs Assessment, Service Plan and reviews, and the Chronological Notes to ensure the youth's issues are addressed in all these areas. The thirty day Service Plan reviews and the Staff Supervision logs were used to assess the internal process of clinical review.

The Non-Residential Supervisor explained that the non-residential staff meet weekly as a group. She is available to meet individually whenever there is a need. Residential Clinical Supervisor also reported meeting weekly with the shelter counselors and interns to review each youth in shelter. Interview with the residential counselor confirmed this process, as well as review of Clinical Meeting notes.

There were no exceptions to this indicator.

2.06 Adjudication/Petition Process

Satisfactory

Limited

Failed

Rating Narrative

The policy and procedure includes all the required elements and further details per the Florida Statute, the members that shall be included on the Case Staffing Committee. The policy also notes other representatives that may be included on the Case Staffing Committee. This policy was last updated on October 2014.

The Case Staffing Committee responsibilities has changed recently due to change in counselors. In an interview with a part-time non-residential counselor and the non-residential Clinical Supervisor, it was explained that the committee meets every other Friday at 8:30 am, and the meetings typically last two to four hours.

There is a standing committee who receive email reminders within the five days of the CIRCUIT meeting. Additionally, there are form letters individualized with pertinent details, sent to families inviting them to CIRCUIT meetings. A copy of these documents are maintained in a binder and in the client files.

Reviewer reviewed two files that went to Case Staffing or CIRCUIT. In one case it was the Counselor who referred the youth to the case staffing. In the other, the parent just showed up the day CIRCUIT was meeting because she wanted services for her son. In the first case, the family and committee was notified within the five day time-frame, as indicated by an email to the Case Staffing Committee and a letter of invitation to the CIRCUIT to the parents.

In both cases, the committee included the required members from the local school district and the DJJ representative or CINS/FINS provider. Additional members of the community were also present as the standing committee also includes representatives from the Community Mental Health and Substance Abuse Agencies.

As a result of the Case Staffing's, new/revised service plans were created and within the seven day time frame, the families received a written report from the meeting that included the recommendations from the committee and reasons for them.

None of the cases went to the judicial intervention level. Each file showed consistent documentation supporting the CINS/FINS Case Staffing Process.

The documents used to review this Indicator were the referrals from the School Board of Brevard County, the CIRCUIT Case Staffing-Service Plan/Report, the letters to the parents, CIRCUIT Staffing Committee Review Forms and the Chronological Service Record, and the copies of emails sent to committee members a week prior to the Staffings.

There were no exceptions to this indicator.

2.07 Youth Records

Satisfactory

Limited

Failed

Rating Narrative

The policy covering youth records denotes adherence to confidentiality laws and specifically addresses the manner in which documentation is completed and the expectation for completion. The policy also addresses transportation of files in a locked container, marked confidential. This policy was last updated in August 2014 and December 2017.

For shelter services, chronological documentation of a clients' ongoing services or contacts are documented on the Robert E. Lehton Children's Shelter Service Record. The Record is to be updated within twenty-four hours of service delivery. Direct Care staff record observations on the Record during each shift. Counseling services are documented by the counselor on the Clinical Progress Note. All documentation is to be factual, specific, and pertinent to the service/contact.

For non-residential services, chronological documentation of on-going services or contacts (provided directly or by referral) is documented on the Non-Residential CINS/FINS Services Chronological Case Notes. The Case Note is to be updated within twenty-four hours of service delivery.

All eight files reviewed were marked confidential and were maintained in a neat and orderly manner. The file room and file cabinets were marked "confidential" and the opaque, locked boxes used for transporting files were also marked "confidential".

This reviewer made note of the confidential stamp on each file, as well as noted the organization of each file. Each section is labeled with a sheet indicating what is in the section.

This reviewer viewed the file room and locked boxes for transportation of files.

There were no exceptions to this indicator.

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 the Department of Children and Families (DCF) for twenty-eight beds and provides residential services to youth in the Department of Juvenile Justice (DJJ) CIN/FINS program and youth from 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 seven 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, playing board and video games. Youth must earn a minimum of 10,000 points to use this room. The sleeping rooms each house two youth. Each youth has an individual bed, bed coverings, and pillows.

The shelter has a fully functional kitchen. 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.

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 admitted to the program are screened using the Florida Network's NetMIS Youth Screening Form and Florida Network Youth and Family Services CINS/FINS Intake Form.

3.01 Shelter Environment

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy in place for Shelter Environment that was last reviewed in November 2017.

The program provides daily programming to engage youth in activities related to health, social, emotional, and physical development.

The Shelter Manager and/or designated Youth Care Staff on each shift are responsible for conducting daily facility and grounds walk through to identify and address any visible problems utilizing the Facility Maintenance checklist.

Outside grounds were well-kept and there were no visual safety hazards. All fire and safety inspections were current.

Each youth has their own individual bed with clean covered mattress, pillows, linens, and blankets. The washers and dryers are operational and the lint collectors are clean.

All surveillance cameras were operable.

There were numerous egress plans of the facility posted. Also, there were Abuse Hotline signs located throughout the facility. The shelter menu was posted and signed by a licensed dietitian.

All program shelter activities were posted and visible for all to see. The youth are engaged in meaningful structured activities. At least one hour of physical activity is provided.

Reviewed: Maintenance/Repair Order Requests, Facility Maintenance Checklist, DCF License

updated 2/2017, Fire Inspection updated 5/23/2017, Health Inspection completed on 11/17/2016 (program is waiting for the Health Department to complete the 2017 inspection), program activity schedules, logbook, shelter menu, program schedule, key control, Safety Data Sheets (MSDS), inventory of chemicals conducted weekly, fire drill logs and emergency drill logs.

Exceptions:

There was graffiti on furniture, bathroom stalls, and walls through out the boys wing. The boys wing bathrooms had toothpaste left in sinks. Shower stalls had some mold. The bathroom floors were dirty and the mirrors had not been cleaned.

In one of the male bathrooms, a sink was inoperable. Many rooms on the boys wing contained numerous pieces of furniture in them, with some of the pieces being broken, for example: wood slates missing, broken or missing drawer fronts, doors and drawers missing, and drawers not working properly.

3.02 Program Orientation

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy in place for Program Orientation that was last reviewed in November 2017.

All youth are given an opportunity to be informed of the program's expectations at orientation within twenty-four of admission to the program. Program staff reviews the program's philosophy, goals, and expectations with the youth. Each component of orientation must be documented by staff on the orientation checklist located in youth client file. Staff and youth sign and date the form.

There were five residential files reviewed. All files documented staff reviewed program rules and behavior management strategies with the youth at intake. All youth were provided with a shelter handbook, explained dress code, and were given a tour of the shelter identifying emergency exits. All five files contained an orientation checklist signed by staff and youth within twenty four hours of admission into the program.

There were no exceptions to this indicator.

3.03 Youth Room Assignment

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy in place specifically for Youth Room Assignment that was last reviewed in November 2017.

The program uses a classification system to ensure appropriate sleeping room assignment. Alerts are entered in the program's alert system during the admission process. Program alerts include youth's special needs, mental health, suicide risk, substance abuse, physical health, and security factors.

At the time of admission to the shelter, the youth are interviewed by the shelter staff to determine the most appropriate sleeping arrangements. The program utilizes the CINS/FINS Intake Form to document information that determines a youth room assigned and alerts.

An alert is immediately entered into the shelter's alert system when a youth is admitted with risk factors such as substance abuse, health issues, mental health, suicide risk and security risks.

There were five open client files reviewed for a completed CINS/FINS Intake Form, room assignment section.

All five had completed CINS/FINS Intake forms. All five had room assignments listed with signatures of

staff and supervisors. Applicable alerts were entered into the shelter's alert system.

There were no exceptions to this indicator.

3.04 Log Books

Satisfactory

Limited

Failed

Rating Narrative

Crosswinds started using the electronic logbooks in July of 2017 and have a drafted policy dated November 2017. The standard is being met.

All electronic logbook entries are to include names of youth and staff involved, pertinent information, time and date, incidents that impact safety and security are highlighted.

The Program Supervisor is to review the logbook weekly and make note in the electronic logbook along with video reviews of the security cameras. When staff are logging in on duty, documentation of reviews are to be documented in the logbook.

A review of the Log was conducted with the Program Supervisor. Random days and time frames were reviewed over the last six months. Incidents were found to be documented and highlighted appropriately. Youth supervision and counts were documented. There were reviews of the Log conducted by staff coming on shift. There were weekly reviews documented by a supervisor. There were no errors observed. All entries were signed electronically by the staff member making the entry.

There were no exceptions to this indicator.

3.05 Behavior Management Strategies

Satisfactory

Limited

Failed

Rating Narrative

The Behavior Management Strategies policy was last reviewed in November 2017.

The program has a behavior management system that is designed to promote positive youth behavior, accountability, and social responsibility. The program has a written description of the behavioral management system that includes positive incentives to encourage participation.

Staff uses a point system that promotes positive youth behavior from the youth that are in shelter. Daily, all the youth participate in group to evaluate their day and their point system card. If youth exhibit maladaptive behaviors, they are given an opportunity to redeem back points and privileges prior to the end of the day. All consequences appear to be fair according to the behavior management system. This writer interviewed a staff member and a youth that were knowledgeable of the behavior management system.

There were no exceptions to this indicator.

3.06 Staffing and Youth Supervision

Satisfactory

Limited

Failed

Rating Narrative

Crosswinds Staffing and Youth Supervision policy was last reviewed in November 2017

The policy meets the staff to youth ratio of one to six during awake hours and one to twelve during sleep hours.

Per shelter policy, there is always one staff on duty of the same gender as the youth. During an interview

with the Shelter Manager, it was shared that the schedule is set up to include leads to ensure there is coverage at all times.

A review of a sample of staff schedules revealed staffing ratios were consistently being met.

The video surveillance system was reviewed and three days were randomly selected to review the staffing ratios as well as ensure overnight bed checks were being done consistently, and were in line with documentation in the log book. The review confirmed that overnight shifts consistently maintained two staff members and that at least one staff is of the same gender as the youth. Bed checks are conducted timely and consistently-- every fifteen minutes.

There were no exceptions to this indicator.

3.07 Special Populations

Satisfactory

Limited

Failed

[Rating Narrative](#)

Policy regarding serving Special Populations was last reviewed in November 2017.

Services are designed to serve court ordered youth who are experiencing serious problems and/or have a history of family issues that have not been resolved. Staff secure services are court ordered services up to 90 days with a possible extension.

There is language that staff assigned to domestic Minor Sex Trafficking youth under this provision will be documented in the daily log book and will document activities in the log book as well. Length of stay is to not exceed seven days. More individualized services are to be provided to youth under this category. This can be evidenced in the youth's case plan and level of supervision and when applicable, additional screening tools, for example, Human Trafficking Screening tool.

There were three youth files reviewed for Domestic Violence services. Case plans were reflective of service needs and length of placement is in compliance with the Indicator. When applicable, youth were transitioned to CINS/FINS or Probation Respite as evidenced by documentation in the file and census.

At the time of the review, there had not been any Staff Secure, Probation Respite or Domestic Minor Sex Trafficking youth served in the previous six months.

There were no exceptions to this indicator.

3.08 Video Surveillance System

Satisfactory

Limited

Failed

[Rating Narrative](#)

The agency has a written policy in place requiring a video system which operates twenty-four hours a day, seven days per week to monitor and capture a recording of agency events. This is in place to assure safety of youth, staff, and visitors.

The agency has a written procedure in place requiring the video system to record twenty-four hours per day so that any incident can be reviewed. Cameras must be placed in exterior and interior locations where staff and youth congregate but not in bathrooms or sleeping rooms and must be visible. The cameras can only be accessed by designated staff as determined by the Chief Executive Officer (CEO) and must be available within twenty-four to seventy-two hours from quality improvement visits and when an investigation is pursued after an allegation of an incident.

The agency maintains a camera system that covers all interior and exterior areas that staff and youth congregate but are not in any bathrooms or sleeping rooms. The camera system operates twenty-four hours per day, seven days per week and are visible throughout the property. A written notice, conspicuously posted, was not found on the agency grounds. Management reported there used to be a sign in the great room of the shelter; however, it was torn down by the youth and never replaced.

The system can capture and retain video and photographic images which are marked with the date, time, and location. This videos can be stored for a minimum of thirty days. The video system does not have the capability to continue operation during a power outage. The shelter manager conducts review of the video, including random overnights, at least every fourteen days as evidenced by entries in the agency logbook.

Only designated staff can access the video. The access is controlled by the CEO and access is limited to the Chief Operating Officer (COO), the Chief Financial Officer (CFO), the Shelter Manager, and the Clinical Director. Each of these parties also has the capability to view the video offsite via their agency-issued laptops or an app on their cellular phones.

According to the COO, third party review of the video is limited to viewing the video with the COO onsite unless a subpoena is issued or requested by the state attorney's office.

Exceptions:

A written notice, conspicuously posted, was not able to be found on the agency grounds. Management reported there used to be a sign in the great room of the shelter; however, it was torn down by the youth and never replaced.

The video system does not have the capability to continue operation during a power outage.

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 the 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 Medication Distribution Record Binder.

4.01 Healthcare Admission Screening

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy in place for Healthcare Admission Screening that was last reviewed in September 2017.

Non-healthcare shelter staff will complete the CINS/FINS Intake Assessment on all youth during the intake process, which includes a physical and mental health screening and assessment. If present on premises, Crosswinds' nurse will conduct the health screening. The policy does not state that the nurse will review the health screening within five business days if it is completed by non-healthcare staff. If a youth presents with a condition, or a condition is identified during the course of services, the staff member conducting the screening must immediately notify the Shelter Coordinator and shelter staff via the "alert system".

Youth with chronic health conditions must have a written contingency and referral plan which documents the symptoms or indicative trigger mechanism for emergency treatment or an acceptable time period for necessary follow-up medical treatment. This plan must be documented in the youth's file and reviewed by all program staff. The youth's parent or guardian shall be actively involved in outlining an appropriate plan and coordinating referrals, appointments and follow-up medical treatment.

Staff will also document the noted condition in the program log book highlighted in yellow along with any specific preventative or emergency measures non-healthcare staff should take to assist the youth with a chronic or acute medical or mental health condition.

There were six files reviewed. All six files documented the physical health portion of the CINS/FINS Intake

Assessment was completed on the day of admission. Out of those six youth, none of the youth had any chronic or acute health condition requiring monitoring or follow-up care. Three of the youth documented a mental health condition and were on medication. This was documented on the form. One youth had different types of allergies and this was also documented on the form and entered in the alert system. One youth documented having Asthma; however, the parent reported the youth does not have an inhaler. One youth had Polycystic Kidney Disorder and documented a special diet was needed.

There were no exceptions to this indicator.

4.02 Suicide Prevention

Satisfactory

Limited

Failed

Rating Narrative

The agency has eight different policies relating to suicide prevention. The policies were all last reviewed in September 2017 by the COO.

All youth will be screened at intake using the CINS/FINS Intake Form. The results are reviewed and signed by the supervisor and documented in the youth's file. If the youth answers "no" to all six screening questions the youth will be placed on standard supervision. If the youth "yes" to any of the six questions or the youth is coming to the shelter directly from a Baker Act facility or returning to the shelter from one the youth is immediately placed on continuous sight and sound supervision until a Suicide Assessment is conducted by a counselor. The assessment will occur no later than twenty-four hours after the screening. The assessment must be completed by a licensed professional or by an unlicensed professional working under the supervision of a licensed mental health professional. If at any time during the screening or while a youth is on continuous sight and sound, any staff observes or believes a youth presents as an immediate threat to themselves or others, the youth will be placed on one-to-one supervision and staff will immediately call 911 and follow Baker Act procedures. The youth must be maintained on precautionary observation until he/she has received an assessment of suicide risk or follow-up assessment of suicide risk by or under the direct supervision of a licensed mental health professional.

There were five files reviewed of youth being placed on continuous sight and supervision at intake due to answering "yes" to at least one of the six screening questions. All five youth were seen within twenty-four hours and a Suicide Assessment was completed by the Licensed Mental Health Counselor (LMHC). All five youth were placed on standard supervision by the LMHC after the assessment was completed. There were thirty-minute observations of the youth the entire time they were on suicide precautions. All observation sheets reviewed documented each shift was reviewed and signed by the on-duty supervisor and each sheet was reviewed and signed by the LMHC.

An interview was completed with the Director of Counseling for the program, who is an LMHC. At the time of the review, the LMHC was the only counselor completing suicide risk assessments for the residential program. However, the LMHC had recently trained two other counselors to complete the suicide risk assessments. Documentation was provided to show both counselors completed twenty hours of training and completed five suicide risk assessments with the LMHC. The LMHC has a very in-depth training process for all new counselors regarding the completion of the suicide risk assessments. The counselors are required to go through a full training program before they are allowed to begin completing their five supervised suicide risk assessments with the LMHC. The LMHC reported only master's level staff with the appropriate degree are allowed to complete this training.

All non-residential counselors are also supervised by the Director of Counseling and are required to complete the same training process prior to completing suicide risk assessments.

The Director of Counseling completes weekly supervisions with all unlicensed counselors. There is one master's level residential counselor and three master's level non-residential counselors. There is also an additional LMHC supervisor for the non-residential program.

There were no exceptions to this indicator.

4.03 Medications

Satisfactory

Limited

Failed

Rating Narrative

The agency has three different policies in place relating to the medication process. The three policies are Medication Verification at Admission and Consent, Medication Storage, Access, Inventories, and Disposal, and Medication Supervision and Monitoring. All three policies were reviewed by the COO in September 2017.

Upon admission, using the CINS/FINS Intake Assessment form, the youth and parent/guardian shall be interviewed about the youth's current medication. The Registered Nurse (RN) will conduct this screening, if available on campus. Otherwise, the interview will be conducted by the on-duty staff and reviewed by the RN within five business days. Procedures for verification of medication include one of the following: contacting the pharmacy, using the Lexi Comp feature of the Pyxis Medication Station, verification by the RN, or using the Physicians' Desk Reference (PDR.net). The method used to verify medication must be documented.

All medications are stored behind at least two locks, in the Pyxis Med-Station 4000 Medication Cabinet and/or locked medication box in the medication room/closed file room. Only staff designated to have access to medication, delineated in his/her job description can access and administer medication. Medication inventory will be conducted by the Shelter Manager, nurse, or other designee. A controlled substance inventory shall be completed each shift with a witness. A weekly audit of non-controlled medications will be conducted. All medications in the Pyxis Med-Station will be inventoried by a RN or Super User if RN is not available within seven days from the last inventory. Controlled and non-controlled medications for disposal shall be inventoried prior to disposal and disposed in the presence of a witness. Medications must be disposed by utilizing biohazard bags and disposed at the local Fire Department.

The shelter provided a list of staff who are trained to assist in the delivery of medications. There were thirteen staff on that list, four of those staff are Super Users.

The shelter does have an RN employed to provide medication oversight. The RN was hired in August 2017 and works for approximately ten hours each week. The RN was not on-site during the two-day review; however, a telephone interview was conducted with her. The RN trains all new hires on the medication administration process and using the Pyxis Med-Station. Re-trainings are completed with staff as needed. The RN completes a full inventory of all medication in the Pyxis Med-Station each time on-site, which is usually two times per week. The RN reported living close to the shelter and comes in when needed. When a new youth arrives the RN will come in and review the health screening form and input medications in the Pyxis Med-Station if needed.

A review of the Pyxis Med-Station was completed with a Youth Care Worker (YCW) who is also a Super User. At the time of the review, there were no open discrepancies. It was reported that there usually are not many discrepancies and when there are discrepancies they are usually wrong counts.

The RN did not know how to use the knowledge portal and did not know any reports needed to be run from the knowledge portal.

There are only three staff members in the shelter who enter new youth/medications into the Pyxis Med-Station, the Shelter Manager, one Youth Care Worker (YCW), and the RN. New medications that enter the shelter are stored in a locked box next to the Pyxis Med-Station until one of these staff members mentioned above can enter it into the Pyxis Med-Station. There are two locked boxes, one for the males and one for the females.

The shelter has six OTC's available for the youth. The six OTC's used at the shelter are Pain Reliever, Ibuprofen, Milk of Magnesia, Maalox, Pepto Bismol, and Antibiotic Ointment. All OTC's were inventoried weekly for the last six months.

The shelter has a sharps box located in both the male and female dorms. There was documentation that all

sharps have been inventoried weekly for the last six months. There is also a sign in/out sheet for razors that documents every time a razor is handed out and to whom.

The shelters disposal procedures include dissolving the pills in the pill container with water and then disposing of them. There have been no medications needing disposal since the last on-site review.

An interview with a YCW revealed medications are refilled when the count is down to five remaining pills. This YCW will fill out a form and give to the youth's counselor for them to contact the guardian to have the medication refilled. If it is not refilled timely shelter staff will also assist in trying to reach the guardian to have the medication refilled.

There were three youth files reviewed of youth who had been on medications. The youth's Medication Distribution Record (MDR) is maintained in the youth's individual file after release. For the current youth, the MDR is maintained in a binder in the medication room. All MDR's reviewed documented the youth's name, date of birth, side effects, physician, allergies, medication the youth was taking with dosage, route, times to be given, and reason. A picture of the youth is located in front of the MDR in the Medication Log Book. All MDR's reviewed on site document that perpetual inventory counts with running balances are being maintained on each youth. All MDR's reviewed for the youth also documented that all medications were given at prescribed times. Inventories of the medications were documented on each shift. All medications in the Pyxis Med-Station are inventoried every shift. Medications were being verified by calling the pharmacy. This was documented on the Medication Receipt, Transfer, and Disposition Form.

The shelter has had no CCC reports relating to medication errors in the last six months.

Exception:

There was no documentation the knowledge portal was being used.

4.04 Medical/Mental Health Alert Process

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy in place that was last reviewed in September 2017 by the COO.

Upon completion of the CINS/FINS Intake Assessment, shelter staff notify the Director of Counseling and shelter staff of any condition(s) the incoming youth present with through the use of the "alert system". The alert system consists of a color-coded dot placed on the front of the youth's file and on the alert board in the staff office in the shelter. The color-coding alerts are as follows: yellow is for suicide, red is for medication/medical, green is for allergies, blue is for sight and sound, orange is for mental health/substance abuse, purple is for physical aggression, and black is for staff secure. Staff will also document the noted condition in the program log book highlighted in yellow, along with any specific preventative or emergency measures non-healthcare staff should take to assist the youth with a chronic or acute medical or mental health condition.

There were six open youth files reviewed. All files documented all intake screening paperwork was completed at admission and any alerts were noted. All six youth had applicable color-coded dots on the front of the file indicating alerts that were identified. The alert board located in the staff office of the shelter was updated with the appropriate color-coded dots for the applicable alerts. Staff interviewed during the review were knowledgeable of the alert system.

There were no exceptions to this indicator.

4.05 Episodic/Emergency Care

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy on Episodic and Emergency Care that was last reviewed in September 2017 by the COO.

If a youth presents with a medical or dental condition at intake, or a condition is identified during the course of services, staff and the Director of Counseling are immediately notified via the “alert system” and appropriate first-aid and/or off-site services will be obtained. All medical, dental, or mental health related incidents that arise during the youth’s stay in the shelter trigger incident reporting procedures, including parental notification, and may necessitate a change to the youth’s alert system status. All changes to the youth’s alert system status are to be promptly reflected on the alert system board, the logbook, and the youth’s case file. All emergency medical and dental treatment must be documented in the youth’s case file and the shelter log book, including all findings, referrals, and follow-up care.

The shelter maintains an Emergency Medical/Dental Care Log. There were three incidents in the last six months of a youth being transported off-site for emergency medical care. These incidents were documented on the Emergency Medical/Dental Care Log. The log documented the youth’s name, the date, time, physical complaint, parent contact, treatment facility, and outcome. All three instances were found documented in the logbook. None of the three incidents were reported to the CCC.

Knife for life and wire cutters are located in the staff office on the male dorm side.

First aid kits are located at the front desk in the shelter, on the female dorm, on the male dorm, the control room, the kitchen, and the van. A review of the First Aid Inspection Sheets binder revealed all these kits are reviewed once per week and restocked as needed. A list is maintained for kit of all items that are to be inside that kit.

The shelter conducts two to three emergency care drills each month. The drills are conducted on various shifts and all staff are involved. The drills are reviewed by the supervisor with critique documented.

Exception:

None of the three off-site emergency care incidents were reported to the CCC.