



Florida Network of Youth and Family Services Quality Improvement Program Report

Review of Crosswinds

on 01/23/2019

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
2.08 Sexual Orientation, Gender Identity/Expression	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	Limited
4.04 Medical/Mental Health Alert Process	Satisfactory
4.05 Episodic/Emergency Care	Satisfactory

Percent of indicators rated Satisfactory:80.00%
Percent of indicators rated Limited:20.00%
Percent of indicators rated Failed:0.00%

Percent of indicators rated Satisfactory:89.29%
Percent of indicators rated Limited:10.71%
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

Keith Carr, Lead Reviewer, Forefront/Florida Network of Youth and Family Services

John Robertson, Program Manager, Florida Network of Youth and Family Services

Paul Czigan, Regional Monitor, Bureau of Monitoring and Quality Improvement, Florida Department of Juvenile Justice

Laterence Reed, Non-Residential Program Director, Urban League of West Palm Beach

Tammy Holcombe, Program Director, Youth and Family Alternatives

Persons Interviewed

- | | | |
|---|--|---|
| <input 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 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 checked="" 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 type="checkbox"/> Human Resources |
| <input checked="" type="checkbox"/> Nurse | | |
| 2 Case Managers | 0 Maintenance Personnel | 2 Clinical Staff |
| 1 Program Supervisors | 0 Food Service Personnel | 3 Other |
| 1 Health Care Staff | | |

Documents Reviewed

- | | | |
|---|--|--|
| <input type="checkbox"/> Accreditation Reports | <input 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 type="checkbox"/> Key Control Log | <input type="checkbox"/> Youth Handbook |
| <input checked="" type="checkbox"/> Logbooks | <input type="checkbox"/> Fire Drill Log | 0 # Health Records |
| <input type="checkbox"/> Continuity of Operation Plan | <input checked="" type="checkbox"/> Medical and Mental Health Alerts | 0 # MH/SA Records |
| <input type="checkbox"/> Contract Monitoring Reports | <input checked="" type="checkbox"/> Table of Organization | 12 # Personnel Records |
| <input type="checkbox"/> Contract Scope of Services | <input type="checkbox"/> Precautionary Observation Logs | 8 # Training Records |
| <input type="checkbox"/> Egress Plans | <input type="checkbox"/> Program Schedules | 4 # Youth Records (Closed) |
| <input type="checkbox"/> Fire Inspection Report | <input type="checkbox"/> Telephone Logs | 4 # Youth Records (Open) |
| <input type="checkbox"/> Exposure Control Plan | <input type="checkbox"/> Supplemental Contracts | 0 # Other |

Surveys

6 Youth 5 Direct Care Staff

Observations During Review

- | | | |
|--|--|--|
| <input checked="" 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 checked="" type="checkbox"/> Tool Inventory and Storage | <input checked="" type="checkbox"/> Facility and Grounds |
| <input type="checkbox"/> Recreation | <input checked="" type="checkbox"/> Toxic Item Inventory and Storage | <input checked="" type="checkbox"/> First Aid Kit(s) |
| <input type="checkbox"/> Searches | <input checked="" type="checkbox"/> Discharge | <input checked="" type="checkbox"/> Group |
| <input checked="" type="checkbox"/> Security Video Tapes | <input type="checkbox"/> Treatment Team Meetings | <input type="checkbox"/> Meals |
| <input checked="" type="checkbox"/> Social Skill Modeling by Staff | <input checked="" type="checkbox"/> Youth Movement and Counts | |
| <input checked="" 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 or CYS) is a contracted member agency with the Florida Network of Youth and Family Services, Inc. to provide Children in Need of Services and Families In Need of Services (CINS/FINS). Crosswinds also provides a range of additional array of services to families and youth under 18 years of age with various risks. The agency serves many profiles, including those who have run away, are truant, and/or ungovernable in Brevard County and from other counties. The agency provides these services through brief onsite short-term residential stays in the youth shelter. Additionally, the agency provides non-residential services to youth and families to youth in area/local schools, or in their homes. Further, other programs and services include transitional housing and skills training for young adults, street outreach for homeless youth, assistance for youth aging out of the foster care system, and intervention services for youth that may be headed toward or involved the juvenile justice system. The program is located at 1407 Dixon Boulevard in Cocoa, Florida. Since its accreditation in 2007 by the Council on Accreditation (COA), Crosswinds has retained its accreditation status and is currently accredited.

Crosswinds maintained operations during Hurricane Irma to include shelter occupancy. The agency competed for Street Outreach Program Funding and Transitional Living Program funding. The agency completed, submitted an application and was awarded by the Department of Health and Human Services. Department of Housing and Urban Development approved funding for \$45,800 for rapid re-housing (a new program for CYS). The agency is also implementing new SNAP programming and staff in the service area. The agency is utilizing a local area BFP transportation contract – awarded to provide school transportation to youth residing in foster homes. The agency began the process to move from ADP for payroll to Paycor for payroll, including a time clock system in the shelter, and some human resource functions. Timecards have been improved and are approved electronically by managers. The process has eliminated most paper timesheets. Further, there is a goal of a paperless personal file. The system includes the onboarding process for new employees. Online access has now been provided to staff to connect with their benefits and compensation. The agency completed the installation of a smoke alarm system powered by the building electrical system was added into the shelter sleeping areas. A new auto leasing agreement was completed and now 3 Honda Odyssey minivans are in service to replace CYS aging fleet of vans. The agency also completed several Information Technology upgrades such as upgraded mail server, fire wall and wi-fi signal strength in multiple buildings on the campus.

Standard 1: Management Accountability

Overview

Narrative

Crosswinds operates both the Robert E. Lehton Children's Shelter (residential) and non-residential CINS/FINS Program primarily in Brevard County. The agency's CINS/FINS program maintains program services, operations, and accountability through staffing that includes a Chief Executive Officer, Chief Operations Officer, Counseling Program Coordinator, and a Shelter Manager. The CEO is responsible for all operations, staff, and services. The COO oversees the activities of both the residential and the non-residential CINS/FINS Program. Program staff includes: Counselors, Lead Youth Care workers, and nearly twenty full and part-time Youth Care Workers. At the time of the review, the program had a minimum number of vacant Youth Care positions. Crosswinds Youth Services is a National Safe Place Program. The agency has a highly structured outreach system that includes promoting and educating the community in general and its system partners on the array of services that it provides. The program has an Annual Training Plan with a specified set of courses for all staff. The minimum number of hours and training is provided to new hires, on-going, and part-time staff members. The agency maintains an individual training file that contains supporting documentation for training topics and hours completed by each employee. Crosswinds has established interagency agreements with several local schools, community-based organizations, government, and other non-profit agencies.

1.01 Background Screening

Satisfactory

Limited

Failed

Rating Narrative

The program has a policy in place which indicates all applicants, including subcontractors and volunteers, will be required to undergo background screening. No applicant may be hired, nor may the services of any volunteer, intern, subcontractor staff, or service provider be utilized until the background screening has been completed. Any person who is required to undergo background screening and refuses to cooperate in such screening or refuses to submit the information necessary to complete screening shall be disqualified from employment. Any person already employed who becomes disqualified shall be dismissed. The persons who must be background screened include all applicants for employment, volunteers and interns, regardless of number of hours they work per month, employees who continue to work in five-year increments.

The agency's human resources department has a detailed background screening process. The agency has a process that requires that all prospective hires be fully screened according to both the Department of Juvenile Justice (DJJ) and the Department of Children and Families (DCF) background requirements. The agency has procedures that require a level 2 background screening that includes live scan fingerprint clearance, National Crime Information Center (NCIC), Florida Crime Information Center (NCIC), as well as local driver's license and local county crime record repositories.

The agency completes a background screening application for all applicants. Each applicant completes the screening process for both DJJ and DCF agencies. Each application is reviewed, and an eligibility rating of pass or failure is given to each applicant. The agency is then able to make an offer of employment. A follow-up screening application is conducted prior to the employee's five-year anniversary date. Regardless of the category, the agency screens all full-time, part-time and volunteers by a uniform standard of background screening process.

The practice observed included ten new hire staff were applicable for initial background screening. Nine of the ten received an eligible background screening prior to hire. One staff received a background screening March 1, 2018 and was hired September 17, 2018 which was beyond the 180 days for which the eligible screening is valid. However, staff indicated the subject staff served as an intern beginning on March 27, 2018. Upon extending an invitation for employment on September 17, 2018, the intern did not require an additional background screening.

Two staff were eligible for five-year rescreening. Both of the applicable staff received a background screening completed within ten days of the anniversary of hire. One additional staff listed on the roster was eligible for 5-year rescreening. The background screening/Clearinghouse documented a rescreening was completed in October 10, 2017 as required; however, staff interviews indicated the staff was no longer with the agency. However, the Clearinghouse still lists this staff as employed with the agency. This related to one staff member and this data was provided to the agency only for information and not considered an exception.

The program provided a copy of the Annual Affidavit of Compliance with Level 2 Screening completed January 11, 2019 along with the email completed the same date in which the Affidavit was forwarded to the Department.

There were no exceptions noted for this indicator.

1.02 Provision of an Abuse Free Environment

Satisfactory

Limited

Failed

Rating Narrative

The program has an employee code of conduct and ethics revised 2014 which includes the code of conduct applies to all employees of Crosswinds Youth Services, Inc. Examples of prohibited behavior include the use of physical harm to staff or youth and threats or intimidation, physical or verbal directly or indirectly a youth, employee or another person. The employee personnel policies and procedures also include in Section 3.0 Organization structure and expectations include the prohibition of profanity.

At all times, youth will have unimpeded access to self-report alleged abuse. "Unimpeded" is interpreted 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.

Grievance policy 1.21 regarding the grievance system.

Youth rights that are subject to grievance include, but are not limited to: shelter, safety, clothing, food, physical healthcare services, mental health and substance abuse services, educational and vocational service, physical exercise, religion, visitation, correspondence, telephone access, discipline and grievances, as part of the grievance process, the youth will receive a written response from the program, and it will be documented in the youth's case file.

The grievance policy includes that the youth is allowed, in writing, to grieve any situation they feel violates their rights and will receive a written response. Youth may grieve actions of staff or conditions. Staff may never deny a youth a grievance form. Youth and their families may complete a grievance form without fear of retaliation. The grievance form can be placed in the locked box located at the Youth Care Worker desk. The box is accessible only to program leadership.

Grievance Form — Part A is attached to the Clients Rights and Responsibilities Form given to the youth and their families at intake. Forms are also available at the grievance box at the Youth Care Worker station in the Shelter Great Room, from the Shelter Manager, at the Juvenile Assessment Center or at the Clevenger Center Administrative office. Direct Care Workers shall not handle the complaint/grievance document unless assistance is requested by youth.

There are three phases to the process. Informal Phase: The youth is permitted to resolve the complaint or condition with staff on duty at time of the grieved situation. The situation shall be documented in the youth's case record and the log book. If dissatisfied, Staff informs youth and their families of the grievance process upon admission to the program. The grievance process is outlined on the Clients Rights and Responsibilities Form.

Formal Phase — Step 1: The youth obtains a grievance form and writes down his/her complaint. The grievance is submitted to the Shelter Manager. The Chief Operating Officer will investigate the facts of the grievance and render a decision within 72 hours of receiving the grievance. If the issue is resolved to the youth's satisfaction, the youth signs that he/she agrees with the resolution of the problem and gives it to the Program Director. If the youth is not satisfied with the proposed resolution,

Formal Phase — Step 2: He/she will request an appointment with the Chief Operating Officer, who will investigate the grievance and issue a decision within 72 hours. The youth signs the resolution of the problem and gives it to the Chief Operating Officer. All grievances are to be signed by staff and youth or the grievance indicates the youth refused to sign. Grievances and findings are maintained in the Finance Department for a minimum period of one year.

Upon review of the shelter found a locked grievance box in the shelter with blank forms available nearby. Interviews with staff revealed the shelter manager checks the grievance box daily and begins the process of responding to the individual. A review of the grievance binder revealed there were three grievances filed in the last six months. All three were resolved within the 72-hour time frame. Two of the grievances documented in the resolution the incident related to perceived bullying would be addressed in transition with staff to ensure youth are being addressed/redirected and reminded staff to document junk behaviors via behavior model of Crosswinds Youth Services incident. Staff interviews indicated this language referred to the supervisor that addressed the incidents verbally with staff at shift change meeting, which interchange is not normally documented.

There were no exceptions noted for this indicator.

1.03 Incident Reporting

Satisfactory

Limited

Failed

Rating Narrative

The agency has a written policy that requires staff to report all reportable incidents to the appropriate sources (Florida D). The agency policy includes content that requires all staff to report and document a broad range of incidents that meet reporting criteria. The policy is required to be reviewed by all staff. All staff members must confirm that they have reviewed and understand the DJJ CCC reporting requirements. All staff receives training on reporting and relative reporting policies during the orientation process upon being hired. The policy also requires the agency to comply with the Florida Administrative Code when reporting to the Central Communications Center (CCC).

The agency must also report all reportable incidents to the CCC within the required two-hour timeframe of incident discovery. The agency has a written procedure requiring all reportable incidents be documented within two (2) hours of the agency gaining knowledge.

The documentation source where all incidents are required to be logged are on the agency's incident reporting form and in the program's

general logbook. Following the completion of the incident, the report is then reviewed for accuracy and completeness and then signed by the program director and Chief Operation Officer or their designee. Appropriate follow up measures are also required to be completed by the agency per the individual request made by the Florida Department of Juvenile Justice and the Florida Network of Youth and Family Services. If staff involved in an incident require management review of their work performance related to the incident, that agency will re-train the staff person and document all actions in the staff person's personnel file. The agency reports the status of any and all personnel actions associated with the specific incident.

A review of five staff training records revealed each new hire staff received training in incident reporting during pre-service training. A review of four in-service staff documented each had received training in incident reporting annually.

An onsite review of all official incidents pertaining to Crosswinds Youth Services that were reported to the CCC in the last six (6) months was conducted on-site.

There were nine incidents reported to the Central Communications Center (CCC) during the review period. Most were reported within the required timeframe. Two of the reports were not reported within the required timeframe. The program maintained an internal incident report associated with one incident which addressed the staff lapse and retraining follow-up. The team was unable to locate an internal incident in the 3 ring binder of incidents in November 2018 related to the November 20 incident to verify staff was addressed regarding the failure to report. The staff provided a copy of the incident report along with follow-up.

A review of the logbook for 11/20/2018 to 11/21/2018 did not reveal any notation of the incident or the presence of law enforcement on campus.

An onsite review of all official incidents pertaining to Crosswinds Youth Services that were reported to the CCC in the last six (6) months was conducted on-site.

Two of the nine CCC incidents were not reported within the timeframe; both were considered failure to report by the Department. One incident involved a razor and Law Enforcement being notified which resulted in an arrest being made. The other incident involved a bar of soap in a sock, being used as a weapon, which resulted in Law Enforcement being called but no arrest was made.

Per the program's policy, all incidents are supposed to be logged on the incident reporting form and in the program's general logbook. The reviewer did not see evidence of real-time incidents being properly documented in the agency's program log book. For example, in a review of the logbook from 11/20/2018 to 11/21/2018, the reviewer did not find evidence that the agency clearly documented an incident that required a request for the presence of law enforcement on campus.

1.04 Training Requirements

Satisfactory Limited Failed

Rating Narrative

The agency has training policies that focus on its efforts to provide training to all staff members. The first training policy is called Training Requirements. The training policy appears that it was last update on October 2017 by the agency's President and CEO. The agency has an additional policy related to Training that is called Training Records. These policies meet the general requirements of the indicator.

The agency has a procedure for Training that requires all new hires to receive 80 hours of training for the first full year of employment and 24 hours of training of training each year after the first year of employment. Further, the agency's procedure requires that all staff complete Orientation and training before the first 120 days and then prior to the end of the first year of employment.

The agency requires all staff members to have a training file. The staff member training file must include a 6-Part file folder that includes a 6 section file folder with a Training Plan; Learning Management System (LMS); Certification; Behavior Management; Other In-Service Training; and Other LMS Student Record. The training file must also include a training log that captures specific topics such as Program Orientation; Crisis Intervention; CINS/FINS CORE; In-Service Training; Other In-Service Training; Other Training and On-Going Employee Training.

A total of eight (8) randomly selected first year and on-going staff members/employee files were reviewed to assess the agency's adherence to meeting all standards and requirements of Staff member Training. All 8 staff members had documented evidence of a training file. In addition, all staff members have up to date training logs that are capturing training topics completed. Of the four (4) first-year staff member files reviewed, all 4 had evidence that major trainings required to be completed in the first 4 months were completed as required. All 4 staff have evidence of completing with 120 days of all the required Department of Juvenile Justice Skill Pro Trainings.

There were no exceptions noted for this indicator.

1.05 Analyzing and Reporting Information

Satisfactory Limited Failed

Rating Narrative

The agency has policies related called 1-15 Quality Improvement Initiatives; 1-19 Program Internal Process Monitoring, 1-27 Analyzing and Report Information Standard Operating Procedures. The policy was last reviewed and approved by the agency President on November 2018.

The agency policies are focused on the agency's approach to executing to analyzing and reporting the policy and procedures for analyzing and reporting data for the following areas including record reviews, incidents, accidents, grievances, customer satisfaction, and outcome data.

The agency has a comprehensive Crosswinds Youth Services Performance and Quality Improvement (PQI) Plan that includes procedures to identify, collect, review, and to report the performance results across various program and operations areas. The information is reviewed by the agency management staff to review any trends, patterns and trends.

The agency has a company-wide PQI Committee that is primarily responsible for executing the review of program operations and program on a quarterly basis. The review includes: 1) Incidents, Accidents, Grievance, and Safety; 2) Performance Measurement; 3) Case Review; 4) Direct Observation; and 5) Communication with staff.

All staff members are required to ensure all aspects of analyzing and reporting data and implementing corrective interventions and actions are consistently implemented and documented. The agency conducts peer reviews for both residential and non-residential programs on a quarterly basis. An agency management PQI team documents the findings on the File Review Form following the completion of each review. The agency procedures require that each review be submitted to the Program Directors and Coordinators. The program then requires that supervisor's complete follow-up is taken by their staff and responded to in a timely manner. The program conducts risk management reviews as part of the quarterly program review process. This team also reviews incident reports and grievances. All of the reviews are assessed and incorporated into a quarterly Program Review Report. The agency also conducts Facility Safety Reviews on a weekly basis. Fiscal year of satisfaction survey results and program outcome data are reviewed on a quarterly basis. The agency also reviews NETMIS data on a monthly basis.

The agency has documentation that provides verification that it is analyzing and reporting on information related to program results to ensure on-going efforts of improving the quality of its program services. The reviewer was provided documentation verifying reports that it generates on a monthly basis. The agency collects and reviews its own program information that includes Florida Network monthly data extracts, NETMIS client information and Florida Network Report Cards. The agency also reviews risk management, CINS/FINS client satisfaction information, Department of Children and Families (DCF), Pyxis Medication Cart reports and other program information documents/reports.

The agency reviews client case records through a monthly quality assurance process that requires them to review a random sample of client case files for accuracy and completion. The agency reviews incidents on a monthly basis to review the agency's practice of how it responds to risk management issues. There is available documentation for supervisors, managers and leadership to review the aforementioned program reports on a monthly basis.

Exceptions are noted for this 1.05 Analyzing and Reporting indicator. Outside of the client case file review, the agency had limited documented information to demonstrate its process for identifying and detecting program service and operations issues. Additionally, the agency does not have significant information or evidence of how strengths and weaknesses are identified, improvements are implemented or modified and how staff are informed and involved in the process.

1.06 Client Transportation

Satisfactory

Limited

Failed

Rating Narrative

The policy indicated Crosswinds staff shall transport youth in personal vehicles. Upon inquiry, staff interviews indicated this was a misprint overlooked in the November 2018 policy review. During the review, the program revised the policy to read Crosswinds staff shall not transport youth in personal vehicles.

When transporting youth, staff will have an approved third party person present in the vehicle. An approved third party person can be another staff, a volunteer, an intern or a youth. Having a third party present helps to avoid situations that put youth or staff in danger of real or perceived harm or allegation of inappropriate conduct by either youth or staff.

Crosswinds does not allow single client transport. 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, and 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. 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. The policy does not include exceptions in the event that a third party is NOT present in the vehicle while transporting.

A review of nine staff training records revealed each staff had completed the SkillPro course (120 transporting youth safely (ninety minutes in duration)).

The program has four vehicles utilized for client transportation. Each of the four vehicles utilized for transportation of youth held a current vehicle

registration, insurance card. The chief financial officer completes a check of driver's license for all program staff prior to hire. A review of three staff files revealed each had a copy of a valid driver's license. The program does not have a list of approved drivers; however, all staff has a valid driver's license reviewed by the administration, twice annually.

The program has four vehicles utilized for the transportation of youth. Staff has a system in which the first shift performs a survey safety check utilizing a vehicle inspection form for each vehicle each day which includes lights, tires, mirrors, windows, fluids, safety equipment, emergency equipment, vehicle interior, and exterior. A review of the daily vehicle checks revealed no discrepancies during the months of October to December.

The program utilizes a Transportation sheet with eight columns for documenting date, destination, driver, beginning and ending mileage, start and end time and passenger. During the timeframe reviewed, it was revealed that there were transports on the 'Transportation Sheet' that failed to document an additional person, either staff or youth that accompanied the single youth. The log book does not clearly identify whether the student transported is DJJ or DCF and after interviewing program staff it was confirmed that some of the CINS FINS youth were single transport with staff only. There was inconsistent documentation in the log book to evidence the supervisor giving approval prior to transport.

Per the agency policy, Crosswinds does not allow single client transport but indicates that there will be an approved third party person present when transporting youth. As two vehicles were off campus, a review of the transportation mileage and time reports for two vans for October 15, 2018 to December 29, 2018 revealed 11 instances of one youth transported alone with no documentation supervisory personnel were notified. In two of those instances multiple riders were noted on the Transportation mileage and time report sheet, however, a review of the logbook revealed the persons/youth accompanying the single youth being transported were not documented nor was there documentation of notification to the supervisor or additional measures taken.

Staff interviews indicated when staff were faced with transportation of one youth alone, they were supposed to take another youth or staff with them. If no one was able to go on the trip, staff were supposed to call the supervisor on the phone and keep the supervisor connected for the duration of the transport. The policy and procedures do not provide direction to staff for transportation of a single youth although there is a practice that is in place and it is inconsistently documented in the logbook.

1.07 Outreach Services

Satisfactory

Limited

Failed

Rating Narrative

Crosswinds Public Awareness and Targeted Outreach Services policy was last updated and reviewed by the COO in November 2018. The policy details required that the agency promote and enter into partnerships that advance their mission to provide quality programs and services to meet the needs of youth and families in the service region. Outreach efforts include, but are not limited to interactions with the public at meetings, presenting at events, phone calls, written correspondence and email, written and verbal requests for information, case management, and attendance at conferences and workshops, as well as formal and/or planned outreach activities. Crosswinds also has a recent written Outreach Plan that includes public awareness and outreach activities targeting youth who are most highly likely to become delinquent or have issues with substance abuse or other negative behaviors.

The COO designates a lead staff member to attend local DJJ board and council meetings in the agency's service region. The agency representative advocates for the effective use of CINS/FINS services where needed in the community and the general service region. Further, the agency representative provides updates to agency leadership on meeting activities following all major community meetings. This individual will also obtain meeting minutes for the file and obtain a copy of attendance at meetings.

The agency promotes its programs and services it provides to the community and its partnerships through various methods including newsletters, local paper, agency website, and Facebook. The COO provided documentation of meetings attended and outreach efforts by the agency from July 2018-January 2019. The agency conducts various fundraisers that include the annual Duck Race. The agency has staff members that regularly attend DJJ Advisory Board meetings. The agency and minutes are maintained in a binder.

There were no exceptions noted for this indicator.

Standard 2: Intervention and Case Management

Overview

Rating Narrative

Crosswinds is contracted to provide both shelter and non-residential services for youth and their families in Brevard County. The counseling/case management for Crosswinds is provided by a Program Coordinator, Residential Counselors, and Non-Residential Counselors. The program provides a comprehensive centralized intake and screening twenty-four hours per day. Upon referral, screening for eligibility is conducted. The agency screens all referrals as a part of the assessment process. Following the completion of an assessment, the designated counselor creates a case plan with the family during the initial session. After the creation of the case plan, the counselor works directly with the family to implement the case plan. Counselors document progress towards completion or non-completion of the service plan goals. Crosswinds does provide Case Staffing Committee services. All CINS/FINS agencies have the capability and are statutorily-mandated to facilitate committees that develop treatment plans for habitual truant, lockout, ungovernable, and runaway youth to address various family issues.

2.01 Screening and Intake

Satisfactory Limited Failed

Rating Narrative

The agency has a written policy and procedure referenced as 2-2 Screening and Intake. The policy was last reviewed and approved by the President in November 2018.

Policy and Procedure indicates services are accessible 24 hours a day a week. During the intake to services, information on available service options, rights and responsibilities, parents 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 forms.

The CINS/FINS Intake Assessment is conducted on each youth entering the program during the face to face visit. The form 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 Shelter Counselors informed that the Needs Assessment is initiated when section B of the youth file is completed. Section B includes screening/assessment tools such as CINS/FINS Risk Factors, ATOD, AADIS, NETMIS Demographics, Suicide Evaluations (if applicable) and Anger/Violence Evaluations.

For Non -Residential services, screenings are completed immediately upon referral by the administration assistant. The assistant enters the NETMIS information and forwards them to the Non-Residential Clinical Supervisor to be assigned to a non-res counselor. The counselor then contacts the family to schedule services as soon as possible, usually the same day.

Reviewer reviewed one open and two closed residential files. All three files contained documentation supporting what was written in the Policies and Procedures, in addition included all the required components. The Shelter intake files were comprehensive of all documentation required to meet the standard, which includes clients rights and responsibilities, grievance procedures and acknowledgment from parents that they received the Parent/Guardian Brochure and written information about service options.

Reviewed three open and one closed non-residential files. All four files contained documentation which was noted in the Policy and Procedures, in addition, included all the required components. It is the practice of the non-residential counselor to supply CINS/FINS handbook along with a packet of educational information/material to the parent and youth at intake. The information provided answers to the 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 agency has a written policy and procedure referenced as 2-3 Needs Assessment. The policy was last reviewed and approved by the President in November 2018.

The Policy and Procedure indicates the Needs Assessment is initiated within 72 hours of admission of youth into shelter care and is completed within two to three face contacts following the initial intake or updated if the most recent Needs Assessment is over six months old, for any youth receiving non-residential services.

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

The Needs Assessment 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 staff.

All three of reviewed residential files contained the Needs Assessment initiated within 72 hours of admission. As noted by the shelter counselors, the Needs Assessment is deemed initiated when section B assessments/screenings documents are completed. All three files contained fully completed Needs Assessments. All Assessments were completed by master's clinicians and were signed off by the licensed supervisor. None of the Needs Assessments resulted in elevated risk of suicide or vindicated a referral for Suicide Assessment.

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

All four non residential files reviewed also had the Needs Assessment completed in the required two of the three face to face contacts. In all four files they were completed in one session. All Assessments were completed by master's level clinicians and all were signed off by licensed supervisor in addition. Not one youth was identified as having an elevated risk of suicide upon completion of the Needs Assessment. As a result no referral for further Assessment of Suicide was needed.

In reviewing files the Needs Assessments addressed current and past issues affecting the youth at time, also his/her current level of suicide risk. The signature on the Needs Assessment indicate the counselor's degree level and supervisory review.

It was observed in one file that the dates on Intake Form (which reads 10/4/2018) didn't match Grievance Forms and notes which states 10/3/2018.

There were no exceptions to this indicator.

2.03 Case/Service Plan

Satisfactory

Limited

Failed

Rating Narrative

The agency has a written policy and procedure referenced as 2-4 Service Planning. The policy was last reviewed and approved by the President in November 2018.

Policy and Procedure states a Service Plan is developed with 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.

In addition, 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 components: Individual needs and goals; Service type, frequency, and location; Persons responsible to complete the goals; Target dates for completion Actual completion dates; Signatures of youth, parents/guardian, counselor, and Supervisor; Date the plan was initiated.

There is a clear and logical relationship between the content of the assessment, the initial service plan and the service plan developed with 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; Most effective means of service delivery; and willingness of youth/family to participate.

The youth and family agree to participate by signing the Plan, in addition to the Case Manager/Counselor and his/her Supervisor. If the parent and youth are not available for signature it should be stated 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 gain knowledge of progress and need for revision.

Eight files reviewed contained completed service plans. All four of the residential files reviewed met the seven day time frame for completing the Service Plan. they were complete in twelve to fourteen days following the Needs Assessment. The residential Service Plan form for the files reviewed included a place for "Date of Initiation."

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 signatures of the youth, parent, counselor and supervisor. Two of the files did not have date by parent signature and one didn't have the date by youth signature. Files reviewed included timely progress updates as well as all required signatures.

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

Per the agency's policy and procedure, the youth and family agree to participate by signing the plan and date plan initiated. If the youth/parent are not available for signature it should be documented on the service plan.

Two of the eight files reviewed did not have the dates of when the parent signed the plan and there was no documentation if they were not available when the plan was initiated.

2.04 Case Management and Service Delivery

Satisfactory

Limited

Failed

Rating Narrative

The agency has a written 2 policies and procedures, 2-5 Services and 2-6 Case Management to address service delivery and case management procedures. The policies were last reviewed and approved by the President in November 2018.

Policy and Procedure indicate each youth shall be assigned a Counselor/Case Manager who will follow their case and ensure service delivery of services through direct provision of referral. The Case Manager/Counselor coordinates services and referrals based upon the ongoing 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 nit limited to: Internal Case Review by Case Manager/Counselors, Consultants (staff directly associated with program) and Supervisors; Peer and Utilization Review (staff that is not directly associated with program); External Case Review by Contraction Agencies; Case Conference Review; Review for notes not summarized, impressions, observations and other information that should be expunged at closing of the record.

All eight files reviewed designate a counselor was assigned and that they coordinate service plan implementation with the youth and family. There was documentation to evidence the assigned counselor located on the Counselor Service Record for residential files and for the non-residential files, it was on the Chronological Case notes. In reviewing the eight files not one contained a referral to Case Staffing Committee. All records showed documentation in the Chronological Notes of the Counselor/Case Manager efforts to engage families and provide parental support throughout services. These notes included school visits, office visits, home visits, and phone calls.

One closed file reviewed contained case termination notes found on Discharge Summary. Notes also included the following: Reason For Discharge, Service Provided, Progress of Youth/Family, Events In Case, Living Arranges at Discharge, Recommendation for Aftercare Services and Arrangements for Case follow up. Eight files reviewed contained referrals, as required/needed.

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

There were no exceptions to this indicator.

2.05 Counseling Services

Satisfactory

Limited

Failed

Rating Narrative

The agency has a written policy and procedure referenced as 2-7 Counseling Services. The policy was last reviewed and approved by the President in November 2018.

The policy and procedure for Counseling Services include 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 case file.

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, each individual group members performance sheet is completed by a facilitator. At the end of the week, all individual performance sheets are to be placed in residents case files.

Eight files reviewed exhibited efforts to engage the families in services in accordance with their case plans. The files show family and individual chronological notes. The youths presenting problems are consistently addressed in the Service Plans review, Service Plans, and Needs Assessment. Chronological notes show clients activities.

The policy and procedure process are documents that are used to review this Indicator. In addition, the Group Counseling log is used to determine frequency of groups; the Needs Assessment, Service Plan, Reviews, and the Chronological Notes to ensure the youth's issues are being addressed in all these areas. Staff Supervision logs and 30 day Service Plan reviews were used to evaluate the internal process of clinical review.

Non Residential Staff meets weekly as a group and if needed the Non-Residential Supervisor is available to meet individually if there is a need. Residential Clinical Supervisor also meets weekly with shelter counselors and interns where each youth in shelter is reviewed.

There were no exceptions to this indicator.

2.06 Adjudication/Petition Process

Satisfactory

Limited

Failed

Rating Narrative

The agency has a written policy and procedure referenced as 2-10 Case Staffing Committee. The policy was last reviewed and approved by the President in November 2018.

The policy and procedure include all the required elements and further details per the Florida Statue, the members that shall be included on the Case Staffing Committee. The policy also notes other representatives that may be included in the Case Staff Committee.

The Committee meets every other Friday at 8:30 a.m. and the meetings typically go on for two to four hours.

There is a standing committee who receive email reminders within 5 days of the CIRCUIT meeting. In addition there are forms of letters individualized with applicable details sent to families inviting them to the CIRCUIT meetings. A copy of these documents are maintained in a binder and in client files.

Reviewer reviewed one file that went to Case Staffing. In this case the committee and family were both notified within the 5 day time-frame, as proof an email was sent to the Case Staffing Committee and a letter of invitation was sent to the parents.

In this case the committee included the required members from the DJJ, CINS/FINS provider and local school district. Additional members of the community were also present as the standing committee which included representatives from Substance Abuse and Community Mental Health agencies.

As a result of the Case Staffing's, reviewed/new service plans were created within the 7 day time frame. As written in policy and procedures families received a written report from the meeting which included the recommendations from the committee and the reasons for these recommendations.

Case did not go to judicial intervention level. The file showed consistent documentation supporting the CINS/FINS Case Staffing Process.

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

There were no exceptions to this indicator.

2.07 Youth Records

Satisfactory

Limited

Failed

Rating Narrative

The agency has a written policy and procedure referenced as 2-7 Counseling/Youth Records. The policy was last reviewed and approved by the

President in November 2018.

The policy covering youth records indicate adherence to confidentiality laws and specifically addresses the manner in which documentation is completed and the expectation for completion. The policy also addresses the transportation of files in a locked container, marked confidential.

For Shelter services, chronological documentation of a clients' ongoing services or contacts are documented on the Robert E. Lehton Children's Shelter Service Record. As a result, the record is to be updated within 24 hours of service delivery. The direct care staff is responsible for recording observations on the record during each shift. In addition, counseling services are documented by the Counselor/Case Manager in progress notes. Documentation is to be specific, pertinent to the service/contact and most importantly factual.

For non-residential services, contacts and chronological documentation of on-going services are documented on the Non-Residential CINS/FINS Services Case Notes. Case Notes are to be updated within 24hours 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 observed by the reviewer at the time of the review and it was observed the youth records were marked "Confidential". In addition, the locked boxes that are used for transporting files were also marked "Confidential".

Each section is labeled with a sheet indicating what is in the section with the Confidential stamp marked on them as well.

There were no exceptions to this indicator.

2.08 Sexual Orientation, Gender Identity/Expression

Satisfactory

Limited

Failed

Rating Narrative

The agency has a written policy and procedure, 3-34 Sexual Orientation Gender Identity and Gender Expression, that was effective July 1, 2018, and was approved by the President.

The policy states that all youth will be treated with respect, provided necessary accommodations, and referred to qualified professionals for supportive services regardless of the youth's actual or perceived sexual orientation, gender identity, or gender expression.

To provide a safe environment and therapeutic case planning for all youth regardless of actual or perceived sexual orientation, gender identity, or gender expression. Agency procedure requires all youth to be addressed according to their preferred name and gender pronouns. Documentation in the logbook and all outward-facing documents and census boards shall also reflect the youth's preferred name and gender pronouns. Youth in need of specialized services related to their gender identity or sexual orientation are referred to qualified resources. When assigning youth to a room, the youth's preference is considered regarding whether they are assigned to a room aligning with their gender identity or not.

4 of 5 staff surveyed stated they are required to address youth by their preferred name and gender pronouns. 1 staff replied they are required to address the youth by the name on their birth certificate and the gender pronouns aligning with the name on their birth certificate. The shelter has original artwork displayed incorporating rainbow colors and words of affirmation. Displayed in common areas are red stop sign signage indicating that the program is an ALLY to the LGBTQ community. Copies of the Florida Network SOGIE zine are available and visible in the common area.

1 staff response to survey states youth are to be addressed by the name and gender pronouns corresponding to their birth certificate. This directly contradicts agency policy.

Standard 3: Shelter Care

Overview

Rating Narrative

Crosswinds provides emergency residential care, 24 hours a day, 7 days a week, for youth primarily 10-17 years of age. The facility is licensed by DCF for twenty-eight beds and provides residential services to youth in the Department of Juvenile Justice (DJJ) CINS/FINS program and youth from the Department of Children and Families (DCF). Residents are provided with a wide range of supportive services such as individual and group counseling, life and social skills training, educational and cultural activities, recreational and community service, youth development/leadership activities, transportation, and linkages to community programs. At the time of the quality improvement review, the shelter was providing services to eighteen (18) DJJ youth, including three Domestic Violence Respite youth. The youth care workers are responsible for conducting all admission-related services for the youth, including orientation and tour of the shelter, and for conducting day-to-day activities with the youth.

3.01 Shelter Environment

Satisfactory

Limited

Failed

Rating Narrative

The agency has a written policy and procedure that addresses all of the key elements of the CQI indicator. The policy was last revised August 2014 and was signed by the President/CEO.

The policy ensures that the shelter environment shall be clean, neat, well maintained, safe, and to the extent possible, reflect a home-like environment. The procedures are well documented. Highlighted practices include furnishings are in good repair and free of graffiti, is free from insect infestation, grounds are landscaped and well maintained, kitchens, dining areas, bathrooms, and shower areas are clean and functional with no graffiti on walls doors, or windows, the Shelter is conducive to providing programming that fosters healthy, social intellectual and physical development, all sleeping quarters have adequate lighting for the tasks performed there and each youth has an individual bed with clean covered mattress, pillow, sufficient linens, and blanket, there is no extraneous cover, wire mesh, paper, cardboard etc. installed over glass, windows, vents or sprinkler heads in the sleeping area, health and fire safety inspections are current; and youth have a safe, lockable place to keep personal belongings.

Other practices include that the Shelter is maintained and cleaned by Shelter youth and staff (Monday-Sunday) within the organization, the Shelter Manager and staff will conduct daily facility and grounds inspections focusing on, but not limited to any cracks or holes in walls or peeling paint; broken windows or furniture, worn carpet or graffiti; poor lighting, dirty glass or cigarette butts on the grounds.

The inspections are documented on the Shift Assignment form and kept on file. Any identified maintenance needs will be documented and transferred to a Maintenance/Repair Order, which is submitted to the Shelter Manager or designee, who will review, prioritize, and submit the request to the Chief Financial Officer (CFO).

During the tour of the facility, an inspection of the shelter environment was conducted. All findings meet the requirements of Indicator 3.01.

During the tour, the furnishings were observed to be in good repair, however, some graffiti was found on furniture in the living room and privilege room and wood slats were missing on dressers in the dorms on the male side. The facility was free of insect infestation. The grounds and landscape are well maintained. Bathrooms and shower areas were found to be clean and functional and no graffiti was discovered in that area. The lighting throughout the facility is adequate.

The program uses the Why Try curriculum and goes outside daily for recreation for an hour.

Youth are given the opportunity to participate in faith-based activities. Youth are given time to do homework and read. The daily schedule is posted and accessible to youth and staff.

All program shelter activities were posted and visible for all to see. The youth are engaged in meaningful structured activities.

There were numerous egress plans of the facility posted throughout the shelter. There were Abuse Hotline signs located throughout the facility as well.

Each youth has their own individual bed with clean covered mattress pillows, linens, and blankets.

Fire and Mock Drills are conducted every month on each shift and kept in a binder.

Chemicals inventories are completed weekly and kept in an MSDS binder as well as having the Safety Data Sheets in Binder.

The program has 3 new vans. One van was off site, so this reviewer was able to check two of the vans. The vans were clean with no graffiti seen. There were first aid kits in both of the vans.

There is a set of lockers with locks for the youth to store any valuable items they may have, with the staff having access to the key.

The DCF License was updated March 15, 2018, Fire Inspection was updated on January 31, 2018 showing violations and then re-inspected on August 7, 2018 showing violations were corrected, Department of Health Inspection was completed on January 18, 2019, Fire Extinguishers were updated September 2018. The Emergency Disaster Plan was updated on March 14, 2018.

Exceptions: Some graffiti was noted on the furniture in the Day Room and in the Privilege Room. The male dorm rooms had some furniture that was missing wood slats.

There was a broken piece of black plastic noticed in one of the showers on the male side.

There were foil containers of food in the refrigerator having covers that were not secure and food was exposed.

One garbage can outside and the one in the dining room had no lid.

The DCF License was not posted in the shelter. The shelter manager stated that it was previously in the lobby but had recently been removed due to disruptive youth.

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 CQI indicator. The policy was last revised August 2014 and was signed by the President/CEO.

The procedures are well documented and include the following information: each resident is to be given an orientation to the operation of the Shelter within 24 hours of admission. Each youth will be given a youth handbook that explains the daily schedule, the behavior management system, and various policies on contraband visitation, telephone rules, etc.

The handbook and each item on the orientation checklist is to be reviewed by staff with the youth.

Upon completion of each aspect of the orientation, the orienting staff will initial the appropriate box on the orientation form. The form is then to be signed by all pertinent parties and placed in the youth's file.

The program has an orientation checklist in each file where the staff goes over all the items with the youth. As each item is discussed, both the youth and the staff initial each item and then sign and date indicating it was completed.

There were four closed files reviewed. Out of the four closed files, one file had paperwork from a previous intake that was dated September 21, 2018 but had no indication that the program orientation was discussed at the current intake. *Follow-up* This file was discussed with the COO and the Director. After researching it was shown that the youth came in as a runaway and once the parent came and filled out the paperwork, he was switched to a respite file and paperwork was copied from the previous file into the new file.

There were three open files reviewed. Out of the three open files, one file had the checklist signed by both staff and youth but neither one initialed the list. One file did not have the signature page for the rights and responsibilities, grievance procedure, abuse and other hotline numbers. In one file the orientation checklist was not initialed by staff.

Exceptions: Out of the three open files, one file had the checklist signed by both staff and youth but neither one initialed the list. (this was corrected by the next day) One file did not have the signature page for the rights and responsibilities, grievance procedure, abuse and other hotline numbers (this was put in the file and is only missing the parent signature). In one file the orientation checklist was not initialed by staff.

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 CQI indicator. The policy was last revised August 2014 and was signed by the President/CEO.

The program uses a classification system to ensure appropriate sleeping room assignments. Alerts include the youth special needs mental health, suicide risk, substance abuse, physical health and security factors.

At the time of admission to the Shelter, the shelter staff determine the most appropriate sleeping arrangements determined by age, susceptibility to victimization, physical attributes, and interactions and observations of the youth. The program utilizes the CINS/FINS Intake Assessment Form to document information that determines a youth room assigned and alerts.

Any program action based on classification must be documented on the Room Assignment section of the CINS/FINS Intake Assessment Form. After the intake, the Shelter Manager or designee determines the most appropriate room for the youth. Youth are not differentiated or discriminated in the assignment of sleeping arrangements.

The program has a board indicating where each youth sleeps as well as any medications and alerts.

There were four closed files reviewed. Each youth file had a completed CINS/FINS intake form signed by staff and supervisor. All but one had rooms assigned.

There were three open files reviewed. Each youth file had a completed CINS/FINS intake form signed by staff and supervisor. All but one had rooms assigned.

Exceptions: Out of the 7 files reviewed, 2 did not have rooms assignments.

3.04 Log Books

Satisfactory

Limited

Failed

Rating Narrative

The agency has a written policy and procedure that addresses all of the key elements of the CQI indicator. The policy was last revised August 2014 and was signed by the President/CEO.

The Shelter maintains an electronic logbook. All intakes, releases, medical information, shift changes AWOLS incidents, and other important information that could impact the security and safety of the program shall be documented in the book.

All entries must contain the date and time of incident event or activity, name of youth and staff involved, a brief statement providing the pertinent information, the name of the person making the entry with the date, time of entry and signature, and important issues that can impact youth or program highlighted in agency assigned colors.

All direct care staff shall review the logbook for the previous two shifts and sign their name and date indicating they have done so.

The Shelter Manager or designee shall review the log at least weekly and note chronologically in the logbook as to any corrections, recommendations and follow-up required. Documentation of the review is to be signed and dated.

The signature and date must be placed at the end of all entries. All errors are stricken through. All major incidents should be highlighted appropriately. Type the census and the names of employees on duty, as well as the date, day, and time at the beginning of each shift. Note all communications with people outside the Shelter (DJJ, DCF, duty counselor, etc.) and include their telephone numbers. All entries should answer who what, where, when questions. At the end of each shift the youth care worker on duty will complete a shift summary to include a client census by gender, status, and first name; new intakes, discharges and self-releases; and any other significant events occurring on that shift. No one can use another person's log in.

A review of the log book with random days and time frames show that staff review the logbook of the two previous shifts and document that they have done so. All recording errors are stricken through then initialed and dated by staff. Thirty minute and fifteen minute checks are documented. The Shelter Manager completes the review of the log and documents findings and corrections that need to made.

Different color highlights are used to make it easy to find different incidents (medication, intake, discharge, youth incident, etc.)

Out of five incident reports found only three were documented and highlighted in the log book. Two separate incidents on November 20, 2018 were not documented in the log book. One included a razor, Law Enforcement being called, and an arrest being made. The other incident included a bar of soap in a sock used as a weapon and Law Enforcement being called with no arrests being made.

Out of five incident reports found only three were documented and highlighted in the log book. Two separate incidents on November 20, 2018 were not documented in the log book. One included a razor, Law Enforcement being called, and an arrest being made. The other incident included a bar of soap in a sock used as a weapon and Law Enforcement being called with no arrests being made.

On two occasions, during youth transports, it was not documented in the log book the the names of youth that went with staff to avoid single youth transports.

3.05 Behavior Management Strategies

Satisfactory

Limited

Failed

Rating Narrative

The agency has a written policy and procedure that addresses all of the key elements of the CQI indicator. The policy was last revised August 2014 and was signed by the President/CEO.

The program utilizes the Boys Town motivation system as trained by Girls and Boys Town. The program uses a Motivation System called the Assessment System that is designed to promote positive youth behavior, accountability, and social responsibility. The program has a written description of the behavior management system that includes positive incentive to encourage participation.

The program uses a point system that promotes positive youth behavior. The youth participate in group to evaluate their day and their point system card daily. The system gives positive points for good behavior and negative points for negative behaviors. If youth exhibit negative behaviors, they are given an opportunity to redeem back points and privileges prior to the end of the day. All consequences appear fair in respect to the behavior management system.

This reviewer interviewed one staff member and one youth and both were able to articulate the policy and procedures regarding the Behavior Management System.

The program did have a store for youth to use their points but no longer utilize it.

There were no exceptions to this indicator.

3.06 Staffing and Youth Supervision

Satisfactory

Limited

Failed

Rating Narrative

The agency has a written policy and procedure that addresses all of the key elements of the CQI indicator. The policy was last revised August 2014 and was signed by the President/CEO.

The provider's procedures require that the Shelter maintains a staff schedule that ensures that staff to youth ratios will be met on all shifts with awake hours for CINS/FINS Youth being a staff to youth ratio of 1 to 6, awake hours for Staff Secure Youth being a staff to youth ratio of 1 to 5 and sleep hours being staff to youth ratio of 1 to 12

There is always at least one (1) staff on duty of the same gender as the youth. A minimum of one (1) staff on duty must be trained in First Aid/CPR. A staff schedule is provided to staff at a minimum of one week in advance and placed in the Team Schedule Book that is located at the Youth Care Worker Station. All changes must be approved by the Shelter Manager at least 24 hours in advance.

In the event of an emergency or staff do not report for their shift the Shelter manager of designee will be immediately contacted to contact staff for duty or as needed to provide staff coverage.

Per the program policy, the staffing ratio of 1 staff to 6 youth during awake hours and 1 staff to 12 youth during sleep hours is consistently being met according to the schedules and the youth rosters that were reviewed. There is at least one staff on duty of the same gender as the youth on each staff. All staff are current on First Aid/CPR.

The staff schedule is provided to the staff and kept in the Staff Office. If a staff is calling out they contact the Shelter Manager who will then find coverage for the shift.

This reviewer checked the video against the logbooks for documentation of staff - youth ratio and bed checks being done consistently. There were no discrepancies found.

There were no exceptions to this indicator.

3.07 Special Populations

Satisfactory

Limited

Failed

Rating Narrative

The agency has individual policies for each y that is called Special Population The agency's policy has content that addresses the requirements of this indicator. The agency policy was last reviewed by the President and CEO on. The agency has policies for DV 331-11/2018; DMST 332 11/2015; Probation Respite 333-09/2016; SOVGI 334; FYRAC 335-07-2018. All individual policies meet the general requirements of the indicator.

The agency has multiple procedures for all 5 individual special populations as follows; policies for DV 331-11/2018; DMST 332 11/2015; Probation Respite 333-09/2016; SOVGI 334; FYRAC 335-07-2018.

The agency only has domestic violence cases. The agency provided 3 cases. All case have documented evidence of cases that include youth that were admitted to DV Respite placement have a pending DV charge and have evidence of being screened by JAC/Detention. All 3 youth files in the program do not have length of stays that exceed 21 days. All 3 youth files have documentation that exist in youth files of transition to CINS/FINS or Probation Respite placement where applicable. In all 3 cases, the agency's case plan in the files of all 3 cases had evidence of services provided to Domestic Violence Respite youth are consistent with all other general CINS/FINS requirements.

There were no exceptions to this indicator.

3.08 Video Surveillance System

Satisfactory

Limited

Failed

Rating Narrative

The agency has a written policy and procedure that addresses all of the key elements of the CQI indicator. The policy was last revised August 2014 and was signed by the President/CEO.

The agency has a written procedure in place to monitor and capture recordings of agency happening to assure the safety of all youth, staff, and visitors on the main campus. The video system records twenty-four hours per day so that any incident can be reviewed. Cameras are placed in exterior and interior locations where staff and youth congregate but not in bathrooms or sleeping room and are visible. The cameras can only be accessed by the 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 program has a video surveillance system in place that covers the interior and exterior areas where youth and staff congregate. There are no cameras in the bathrooms or in the bedrooms. The video surveillance system operates twenty-four hours a day and the cameras are visible throughout the property. There is a written notice of the video surveillance system that is posted in the entrance to the building.

The video surveillance system can capture and retain recordings for a minimum of thirty days and marked with the date, time, and location of the recording. The video surveillance system has a backup in case of power outages. The Shelter Manager conducts a review of the recordings including random overnight bed checks at a minimum of every fourteen days and indicates the review in the log book.

According to the Shelter Manager, only management can access the video. No staff are allowed to view the video and the COO handles third-party requests to view video.

This reviewer checked the video against the logbooks for documentation of bed checks being done consistently. There were no discrepancies found.

There were no exceptions to this indicator.

Standard 4: Mental Health/Health Services

Overview

Rating Narrative

Crosswinds Youth Shelter conducts admission, interviewing, classification and assessment services to fulfill the safety and appropriate supervision required to perform on all youth admitted to the program. Upon admission, trained program staff screen, interview, classify and assess youth. Specifically, the agency has staff members that are trained to screen all youth and identify youth who are admitted with special needs and risks, such as risk of suicide, mental health, substance abuse, physical health, or security risk factors. Following this, the agency is better able to determine the youth's needs, issues and health status of all youth. The agency also has staff members that are licensed clinical professionals that oversee the clinical program and services provided to clients. The agency staff members use the CINS/FINS Intake form on all clients. The staff are trained to notify management of the presence of any risks and/alerts are present.

The agency has direct care staff that are trained during orientation to administer first aid and CPR on an as needed basis. The program has a list of staff who are trained by the agency's licensed registered nurse that is authorized to distribute medication to residents during their shelter stay. The agency uses an alert system that includes a medical and mental health alert function to alert staff on the status of all residents in the facility.

4.01 Healthcare Admission Screening

Satisfactory
 Limited
 Failed

Rating Narrative

Agency policy 3.17 dictates that non-licensed staff are to conduct the initial physical and mental health screening during the CINS/FINS Intake Assessment, unless the nurse is on-site. This includes a survey of the following:

Current medications

Existing medical conditions

Allergies

Recent injury or illness

Presence of pain or other physical distress

Observation for presence of scars, tattoos, injuries, physical distress, and indications of substance abuse.

If the youth has specific needs or risks related to their health this is indicated as part of the color-coded alert system.

Health screening assessment begins at the screening process, and continues through the intake process. a youth are interviewed regarding the possibility of conditions identified above. Observations of the youth are also made by the staff person conducting the intake. If the youth presents with any chronic or acute medical needs they are referred out to professional medical care, a parent or guardian is contacted to transport the youth, or if urgent, staff will transport youth to care, or call 911 for ambulance service.

The agency adheres to their policy which is congruent with contractual expectations for all youth placed under Florida Network program status. Of 4 files reviewed all healthcare screenings were completed as evidenced by documentation in youth files. When necessary, conditions were noted on the file and the census board according the a medical/mental health alert system. The nurse, when interviewed, described a process for evaluation of youth on-site, review of files since last on-site visit, and referrals to medical care when deemed necessary or recommended.

There were no exceptions to this indicator.

4.02 Suicide Prevention

Satisfactory
 Limited
 Failed

Rating Narrative

Policy 4.12 governing the assessment of suicide risk was last reviewed in 2014. The policy states that all youth 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 case file.

If the youth answers "No" to all 6 questions the youth is placed on Standard Supervision. If the youth answers "yes" to any of the 6 questions

OR is coming to the shelter directly from a Baker Act facility (Circles of Care) or returning to the shelter from a Baker Act facility, the youth is placed immediately on Continuous Sight and Sound Supervision until a suicide assessment is conducted by a counselor. This will be noted in the log book, and staff will immediately begin the Suicide Precautions-Observations Log. Immediately, and at each shift, a shelter staff is identified and responsible, for supervising that youth as they remain on Continuous Sight and Sound.

If at any time during the screening OR while a youth is on Continuous Sight and Sound, any staff observes or believes the youth presents 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. This will be noted in the log book, and shelter staff will immediately begin the Suicide Precautions-Observations Log. Immediately, and at each shift a shelter staff person will be responsible for supervising that youth as long as they remain on One-to-One Supervision.

Youth is screened for suicide risk upon intake. Screening results are reviewed by supervisor and documented in the case file. If indicated, youth is placed on sight and sound observation until evaluated by a licensed counselor or a non-licensed counselor under the supervision of a licensed counselor. Youth is placed under the appropriate level of supervision based on the results of the suicide risk assessment. Staff person assigned to monitor youth documented behavior at intervals of 30 minutes or less. Supervision level was not changed until a licensed professional or a non-licensed mental health professional completed a further assessment OR Baker Act by local law enforcement.

7 closed files were reviewed for all elements of the suicide risk screening and assessment process. 7 of 7 contained the appropriate screenings, assessments, and observation logs as required. The licensed LMHC conducts intakes at times, and when suicide risk is indicated, implements the assessment at intake, which precludes the need for an observation log if the youth is determined to not be at risk of suicide at that time. Case notes and planning align with the identified risk factors and indicators of concern for suicide. Licensed LMHC, Director of Counseling, is very involved in the assessment process, supervision of counselors acquiring licensure, and training of counselors to conduct assessments independently.

There were no exceptions to this indicator.

4.03 Medications

Satisfactory

Limited

Failed

Rating Narrative

Agency policy 4.07 governs the verification, storage, and administration of patient-owned medications. The medication room is not accessible to youth and all medications are stored behind a minimum of two locks. Medication requiring refrigeration is stored in a dedicated, locked, refrigerator. Oral medications are stored separately from injectable (epi-pen only) and topical medications. Syringes and sharps are inventoried weekly and policy requires the minimum amount of sharps necessary should be on-site at any given time. A roster of staff is maintained detailing who has permission to access the Pyxis Med-Station 4000.

Inventory of non-controlled medications is conducted by the shelter manager, nurse, or other designee weekly. Policy dictates that inventory must be observed and documented by a witness if conducted by a Super-User. The RN administers all medications when on-site as required by policy. Youth-owned medications are verified by the RN if on-site or by youth care staff by contacting the prescribing pharmacy, or one of two pharmacies available by phone to insure the medication in the container matches the expected physical description. Staff document all medication transactions in the medication distribution log as a redundant back-up to the Pyxis activity log. Shelter Manager receives monthly reports via the Knowledge Portal pre-set reporting functions, and access the Knowledge Portal as needed for specific inquiries.

The program maintains 3 Super Users. All demonstrated proficiency with the required functions of the Pyxis Med-Station 4000. All prescription medications were stored in the Pyxis and an inventory was provided on request by the Shelter Manager. A report is provided at the beginning of each shift detailing the youth who are to receive medications, what medications, and what time the medication is to be delivered. The practice appears to be consistent and all staff interviewed were aware of the process and expectations for assisting in the delivery of the medications.

Exceptions: Policy states that discrepancies are to be cleared each shift. Current practice is to clear discrepancies daily, or every couple of days.

Inventory of medications is not being done according to Network policy. Crosswinds policy does not align with stated standards.

Non-controlled medications are to be inventoried weekly by the nurse or a Super User. If conducted by a Super User, they must have a witness documented in the Pyxis machine.

OTC medications are currently stored in locked boxes. Policy requires them to be stored in the Pyxis machine.

Controlled substances are not being inventoried each shift and are not verified by a witness.

Full name of medications are not being entered into the "Alt Med ID" field.

4.04 Medical/Mental Health Alert Process

Satisfactory

Limited

Failed

Rating Narrative

Policy states that upon completion of the intake assessment, shelter staff notify the Director of Counseling and all shelter staff of any conditions the in-coming youth presents with through the use of the alert system. The color coded system is consistent throughout the youth files and on a confidential census board behind a locked door. The condition is also noted in the logbook, highlighted in yellow 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.

Upon intake the youth is questioned and observed for indications of medical or mental health conditions, food allergies, medication side effects, medication allergies, and other conditions indicated for the alert process. If such conditions exist, the alerts are placed on the outside of the file with a color-coded dot system, noted in the logbook and highlighted, and indicated on the confidential census board behind the staff station. Instructions for staff are provided for recognizing and responding to emergency situations based on the potential risk or threat indicated by the youth's condition.

Upon review of 4 active files, interview with shelter manager, and observation of the logbook and census board, the program is conducting the practice as stated in the aforementioned procedure. 10 youth in shelter at the time of this review were placed on one or more alerts.

There were no exceptions noted for this indicator.

4.05 Episodic/Emergency Care

Satisfactory

Limited

Failed

Rating Narrative

The agency policy 4.09 stipulates that the staff have discretion and authority to call 911 for any youth for any reason they deem necessary. The policy was last reviewed in 2015 by COO Karen Locke. When youth present with medical or dental condition at intake, Director of Counseling is to be notified to initiate contact with the parent or guardian. If the parent or guardian cannot transport the youth to the necessary level of care, the agency will transport youth to urgent or emergency care, which may initiate a call to the DCF Abuse hotline if it is determined the parent or guardian is acting in a negligent manner by refusing to transport.

All medical and mental health conditions are indicated on the file by a color dot sticker system which adheres to a key defining common and uncommon conditions.

Procedure details the following:

is off-site emergency medical or dental care required?

Was an incident report submitted?

Was parent or guardian notified? If so, were they able to transport? If not, why not?

Upon youth return, is there verification of medical clearance via discharge instructions with follow-up?

Is the incident also recorded in the daily log?

All of this information is detailed in both the logbook and the youth file. The Emergency/Medical Dental Care Log is also kept in a separate binder for reference of all incidents.

There were 34 documented incidents of medical or dental emergencies in the reviewed period. Each incident indicates that the parent or legal guardian was first contacted to transport youth to medical aid, and when unable to do so, agency staff transported the youth to services. All incidents documented follow up if youth was cleared and returned to shelter.

There were no exceptions noted for this indicator.