Florida Network of Youth and Family Services
Compliance Monitoring Report for

Crosswinds Youth Services
1407 Dixon Boulevard
Cocoa, FL 32922

Compliance Monitoring Services Provided by

FOREFRONT

EXECUTIVE SUMMARY

Introduction

Forefront LLC conducted a joint QI and Florida Network of Youth and Family Services (FNYFS) contract monitoring visit for the Crosswinds Youth Services CINS/FINS program, for its FY 2019-2020 contract, on November 20-21, 2019 at the 1407 Dixon Boulevard, Cocoa, Florida site. This onsite program review included the review of both Children in Need of Services/Families in Need of Services (CINS/FINS) residential and non-residential program services.

The DJJ QI Team consisted of Keith Carr, Lead Reviewer and Consultant, Forefront LLC; Nitara Latouche, Consultant, Forefront LLC; Aimee Johnson, Residential Specialist, Youth and Family Alternatives, Teresa Andersen, Deputy Supervisor/Regional Monitor, Bureau of Monitoring and Quality Improvement, Florida Department of Juvenile Justice. Crosswinds Representatives include Karen Locke, Chief Operations Officer (COO); Lynn Cowart, Chief Financial Officer; John Weimann, Clinical Director; Pierre Bandoo, Shelter Manager; Mike Seulle, Director of JAC; Myrna Peterson-Weimann, Clinical Supervisor; Rosa Thompson, Counselor; Charlene Morris, Counselor; Ana Loyselle, Counselor; Danielle Masucci, SNAP Coordinator; Nikeisha Jones, Counselor; and Cydney Larson, Counselor. All participants at the entrance conference are documented on the QI Entrance Conference Attendance Log.

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 broad range of services to families and youth under 18 years of age with various risks. The agency serves many profiles, including youth that have run away, truant, and/or ungovernable in Brevard County and from other counties. 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.

Crosswinds Youth Services, Inc. (Crosswinds) also serves youth referred for domestic violence, probation respite, court-ordered and lockout youth in Brevard County and from other counties. The agency also operates a Stop Now And Plan (SNAP) program that services this region of the state. The agency has been accredited since 2007 by the Council on Accreditation (COA). At this time, Crosswinds retains its COA accreditation rating. Crosswinds Youth Services is also a National Safe Place Program site. Crosswinds delivers its services through both onsite short-term residential stays in their emergency youth shelter and out-patient non-residential counseling services. Crosswinds non-residential program services are provided to youth and families in Brevard County in the local schools, community locations (libraries, community centers, youth after school programs) or in their homes. Crosswinds also provides other services including transitional housing, street outreach for homeless youth, life skills training for young adults and services for youth aging out of the foster care system.

In general, the Reviewer found that the Crosswinds Youth Services CINS/FINS program is in compliance with the Administrative and Fiscal standards based on the current contract requirements. Specifically, the provider achieved an acceptable rating on all fourteen (14) applicable items of the

CINS/FINS Monitoring Tool. The overall rate of compliance for this program review is 100%. There are no corrective actions cited and no recommendations were made as a result of the contract monitoring visit.

The following report reflects the findings from the compliance monitoring tool used on site during the program review. These findings are an assessment of the provider's compliance with Administrative and Fiscal requirements of the CINS/FINS contract. A copy of the monitoring tool utilized during the visit and related documentation submitted by the provider are on file with the Reviewer. If any information or clarification is required, please contact Keith Carr by email to keithcarr@forefrontllc.com.

2019-2020 CINS/FINS PROGRAM COMPLIANCE MONITORING TOOL
Report Number: CM 11-20-21-2019-2020

Agency Name: Crosswinds Youth Services	**Monitor Name: Keith Carr**
Contract Type : CINS/FINS	**Region/Office: 1407 Dixon Blvd., Cocoa, FL 32922**
Service Description: Comprehensive Compliance Monitoring	**Site Visit Date(s): November 20-21, 2019**

Major Programmatic Requirements	Explain Rating: Unacceptable	Conditionally Unacceptable	Fully Met	Exceeded	Not Applicable	Ratings Based Upon: I = Interview; O = Observation; D = Documentation; PTV = Submitted Prior To Visit; (List Who and What)	Notes: Explain Unacceptable or Conditionally Acceptable: (Attach Supportive Documentation)
I. Administrative and Fiscal							
DJJ Quality Assurance Peer Reviewer a. Provider shall demonstrate that a minimum of two (2) staff members have been trained to be certified as DJJ QA Peer reviewers. Provider shall participate in a minimum of one (1) on-site quality assurance review of a similar type program in another judicial circuit during each 12-month period of the contract, if requested. **Obtain from FNYFS**	☐	☐	☒	☐	☐	**D:** The following staff members have been trained as Certified DJJ QA Peer Reviewers: Lynn Cowart, Pierre Bandoo, John Weinman and Raylene Coe(2 QI outings this FY). The agency has participated in 2 QI peer reviews in 2019-2020.	
DJJ Annual QA Audit a. Provider shall achieve and maintain an overall "Acceptable" performance rating per QA standards. The Provider shall develop a corrective action plan within 30 days of receiving less than overall "Acceptable" rating. A copy of the corrective action	☐	☐	☒	☐	☐	**D:** The previous year's FNYFS QI program review was conducted on April January 23-24, 2019. The agency received a Satisfactory Compliance Rating of 89.2% and a Limited compliance rating of 10.71%. A corrective action plan for Indicator 1.03 was completed.	
Additional Contracts a. Provider shall provide a listing of all current federal, state, or local government contracts, as well as other contracts entered into with for profit and not-for-profit organizations. Such listing shall identify the awarding entity and contract start & end dates. **PTV**	☐	☐	☒	☐	☐	**D:** The provider reported nearly (10) additional funding/contracts outside of FNYFS funding Brevard County Housing and Human Services Department; Brevard County Housing Finance Authority; Brevard County Sheriff's Office; Brevard Family Partnership Community Based Care of Brevard Inc; State of Florida Department of Children and Families: Brevard Production Inc.; Communities Connected for Kids; National Safe Place: Partnership for Strong Families, Inc: School Board of Brevard County:	

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						Department, Brevard Homeless Coalition, Childrens Network of Southwest Florida, Kids Central, Inc., and Community Partnership for Children. Information on the aforementioned programs included type of program, funding source, program description, contract period, and funding amount.	
Limits of Coverage a. Provider shall provide and maintain during this contract, the following minimum kinds of insurance: Worker's Compensation and Employer's liability insurance as required by Chapter 440, F.S. with a minimum of $100,000 per accident, $100,000 per person and $500,000 policy aggregate. Commercial General Liability with a limit of $500,000 per occurrence, and $1,000,000 policy aggregate. Automobile Liability Insurance shall be required and shall provide bodily injury and property damage liability covering the operation of all vehicles used in conjunction with performance of this contract, with a minimum limit for bodily injury of $250,000 per person; with a minimum limit for bodily injury of $500,000 per accident; with a minimum limit for property damage of $100,000 per accident and with a minimum limit for medical payments or $5,000-$10,000 per person. Florida Network is listed as payee or co-payee. **PTV**	☐	☐	☒	☐	☐	**D:** Certificates of Limits. **General Liability**: $ 1,000,000 Each Occurrence, $3,000,000 Aggregate, $3,000,000 Comprehensive Aggregate through First Non-Profit Insurance Co., effective 10/21/2019-10/21/2020. **Workers Compensation:** $100,000 Per Accident, $100,000, Each Employee, $500,0000 Policy Limit. **Automobile Insurance:** $1,000,000 combined single limit effective 10/21/2019 - 10/21/2020. Medical payments amount is listed on the policy for $5,000. However, the combined limit of $1million is adequate to cover medical payments in excess of that amount. Florida Network is listed as Loss Payee on the certificate.	

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External/Outside Contract Compliance a. Provider has corrective action item(s) cited by an external funding source (Fiscal or Non-Fiscal). **ON SITE**	☐	☐	☒	☐	☐	**I, D:** During the Entrance Conference, the provider indicated that there are no outstanding corrective action item(s) cited by an external funding source.	
Fiscal Practice a. Agency must have employee and fiscal policy/procedures manuals that are in compliance with GAAP and provide sound internal controls. Agency maintains fiscal files that are audit ready. **PTV**	☐	☐	☒	☐	☐	**D:** The agency has an Accounting Procedures Manual that is designed to be consistent with Generally Accepted Accounting Procedures (GAAP) and provide for limited internal controls. Records indicate that this manual was last updated January 2019 and was approved by the agency's CEO.	
b. Agency maintains a general ledger and the corresponding source documents. General ledger must be set up to track the activity of the grant separately (standard account numbers / separate funds for each revenue source, etc.). **PTV**	☐	☐	☒	☐	☐	**D:** Agency maintains a detailed cost accounting general ledger system with corresponding source documents. General Ledger is structured to track all funding sources and there are separate funds for each revenue source. The GL for the CINS/FINS cost center for the current FY July 2019 – October 2019, were reviewed and was found to meet the requirements of the indicator.	
c. Petty cash ledger system is balanced and all cash disbursements are compliant with financial policies and allowable under the contract. (disbursements/invoices are approved & monitored by management). –**ON SITE**	☐	☐	☒	☐	☐	**D:** Petty cash is stored in a secure location in the Shelter Manager's office. The agency designates an alternate custodian in the absence of the COO as needed. All cash disbursements are allowable and are documented on a Petty Cash listing. Receipts are submitted for reconciliation and record keeping.	

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	Unacceptable	Conditionally Unacceptable	Fully Met	Exceeded	Not Applicable		
						The established petty cash fund amount is $300 and may be increased if necessary. The agency provided reconciliations for the past six (6) months. Copies of the petty cash process and fund reconciliations were reviewed. Petty cash is replenished and reconciled weekly or on a as needed basis.	
d. Financial records and reports are current. Includes bank statements reconciled within 6 weeks of receipt. Vendor invoices past 6 months. Invoices are submitted on a monthly basis with supporting documentation. (disbursements/invoices are approved & monitored by management). **ON SITE**	☐	☐	☒	☐	☐	Documents reviewed included Bank Statements and Bank Reconciliations for account with Bank of America for the period May 2019 through October 2019. Financial Statements are reported on a monthly basis. Statements are consistent with bank reconciliations and are also conducted on a monthly basis. These are generated within the first two weeks of the following month for the prior month's statements. The Agency's CFO oversees the process and a Business Specialist documents the journal entries on a monthly basis. All accounts payable and cash receipts are still being recorded. The agency maintains individual vendor files which are kept in secure file cabinets in the finance office and disbursements are approved by management. Monthly invoices for the Florida Network are submitted with supporting documentation.	

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e. Agency maintains inventory in accordance with a written policy and FNYFS contractual requirements. If over $1,000 inventory has DJJ Property Inventory Number/Tag. In the event the provider has purchased computer equipment an Informational Resources Request (IRR) been submitted to DJJ. **PTV/ON SITE**	☐	☐	☒	☐	☐	**I, D:** The agency provided a listing of inventory purchased with FNYFS funds. The agency purchased ten (10) desk top work computers in April 2016. Inventory items are labeled as required.	
f. Agency submits payroll taxes and deposits (and retirement deposits as applicable), Employee IRS Form W-2 and Independent Contractors IRS Form 1099 forms prior to federal requirements. **ON SITE**	☐	☐	☒	☐	☐	**D:** The agency uses a contracted payroll service provider to do payroll. The agency uses Paycor for payroll and taxes. Evidence of the submission of the required quarterly payroll taxes was provided via copies of 941s, 1st through 3rd quarters of 2019 demonstrating the filing of payroll taxes. No overages or adjustments were documented on the last quarter's report. ADP also submits the W2s electronically.	
g. Budget to actual reports prepared and reviewed by appropriate management. Variance from the budget are investigated and explained. **PTV/ON SITE**	☐	☐	☒	☐	☐	**D:** Budget to Actual, Combined Funds Status Report, for the FY 3 months ending October 31, 2019. The CEO and CFO review the variances monthly and quarterly with the finance committee of the Board of Directors. Expenses are approved prior to expenditure to place controls on spending.	
h. A Single Audit is performed as part of the annual audit if expenses are greater than $500,000. The agency must submit a Corrective Action Plan for findings cited in the management letter and single audit. An annual financial audit was completed within 120 days after the previous fiscal year/calendar year and that a	☐	☐	☒	☐	☐	**D:** The agency has a single audit that was submitted directly to the Florida Network. Per the audit report, a management letter was not required.	

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	Explain Rating						
Major Programmatic Requirements	Unacceptable	Conditionally Unacceptable	Fully Met	Exceeded	Not Applicable	**Ratings Based Upon:** **I = Interview** **O = Observation** **D = Documentation** **PTV = Submitted Prior To Visit** **(List Who and What)**	**Notes** **Explain Unacceptable or Conditionally Acceptable:** **(Attach Supportive Documentation)**
been requested and approved in writing. Copy of Audit is submitted to the FNYFS by December 31st. **Obtain from FNYFS**						This document had no reported audit findings. As a result of this, a corrective action response plan was not required.	
i. Agency maintains confidentiality policy with written policies and procedures to ensure the security and privacy of all employee and client data. Personal information is not easily accessible. Agency maintains a backup system in case of accidental loss of financial information. Security procedures are in place to protect laptops. Obsolete documents are shredded and computer hard drives are wiped prior to discarding. **ON SITE**	☐	☐	☒	☐	☐	**D:** Crosswinds Youth Services CINS/FINS residential and non-residential services Standard Operating Procedures for Confidentiality, Record Retention, Record Loss Prevention, Client Record Management, and Mobile Computing and Storage Devices are maintained and were reviewed on site. No changes were made to these documents.	

CONCLUSION

The Crosswinds Youth Services agency has achieved Satisfactory status and meets the general performance standards in Administrative and Fiscal compliance areas. The overall rate of compliance for this program review is 100%. The findings indicate that Crosswinds Youth Services residential and non-residential program is in compliance with the Administrative and Fiscal standards based on the current contract requirements. Specifically, the provider achieved an Acceptable rating on all twelve (12) applicable items of the CINS/FINS Monitoring Tool. Two (2) of the indicators were rated Not Applicable because the provider does not have any outstanding corrective action item(s) cited by an external funding source. In addition, there is no program inventory or recent computer purchases made with DJJ funds.

If required, responses to items cited for corrective actions are due to the Florida Network and the Florida Network Contract Manager within fourteen (14) working days of receipt of this report (See Florida Network Site for the Service Provider Corrective Action Form). The Florida Network Contract Manager will then review the response to the corrective action(s) to determine if the response adequately addresses the problem identified in the report within three (3) days. Upon approval the provider will then implement the approved measure to address the item(s) cited in the report. If the corrective action is successful in resolving the items cited in the report the contract monitor will notify the Provider in writing that the desired resolution has been achieved. Log on to the Florida Network (www.floridanetwork.org) website forms section and download the Service Provider Corrective Action Tracking Form.

The Florida Network recognizes Jan Lokay, Chief Executive Officer and all of her staff for their efforts to deliver high quality CINS/FINS services to program participants and their families in this service region. In addition, we would like to thank all management and direct care residential, non-residential staff, operations, program, youth shelter, food service, maintenance and support and administrative staff for providing assistance during this review.

Florida Network of Youth and Family Services Quality Improvement Program Report

Review of Crosswinds Youth Services - Cocoa
Residential Program

November 20-21, 2019

Compliance Monitoring Services Provided by

FOREFRONT

CINS/FINS Rating Profile

Standard 1: Management Accountability

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

Percent of indicators rated Satisfactory: 57.14%
Percent of indicators rated Limited: 42.86%
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 & 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
2.09 Special Populations	Satisfactory
2.10 Stop Now and Plan (SNAP)	Limited

Percent of indicators rated Satisfactory: 90.00%
Percent of indicators rated Limited: 10.00%
Percent of indicators rated Failed: 0.00%

Standard 3: Shelter Care & Special Populations

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

Percent of indicators rated Satisfactory: 71.43%
Percent of indicators rated Limited: 28.57%
Percent of indicators rated Failed: 0.00%

Standard 4: Mental Health /Health Services

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

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

Overall Rating Summary
Percent of indicators rated Satisfactory: 79.31%
Percent of indicators rated Limited: 20.69%
Percent of indicators rated Failed: 0.00%

Rating Definitions

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

Satisfactory Compliance	No exceptions to the requirements of the indicator; limited, unintentional, and/or non-systemic exceptions that do not result in reduced or substandard service delivery; or exceptions with corrective action already applied and demonstrated.
Limited Compliance	Exceptions to the requirements of the indicator that result in the interruption of service delivery, and typically require oversight by management to address the issues systemically.
Failed Compliance	The absence of a component(s) essential to the requirements of the indicator that typically requires immediate follow-up and response to remediate the issue and ensure service delivery.
Not Applicable	Does not apply.

Reviewer

Members

Keith Carr - Lead Reviewer Consultant-Forefront LLC/Florida Network of Youth and Family Services

Teresa Andersen - Department of Juvenile Justice

Nitara LaTouche – Consultant - Forefront LLC

Linda Sessions – Hillsborough County Children Services

Aimee Johnson – Youth and Family Alternatives, Inc.

Quality Improvement Review

Crosswinds Youth Services – November 20-21, 2019
Lead Reviewer: Keith Carr

Methodology

This review was conducted in accordance with FDJJ-1720 (Quality Assurance Policy and Procedures), and focused on the areas of (1) Management Accountability, (2) Intervention and Case Management, (3) Shelter Care, and (4) Mental Health/Health Services which are included in the Children/Families in Need of Services (CINS/FINS) Standards (July 2019).

Persons Interviewed

- ☒ Chief Executive Officer
- ☐ Chief Financial Officer
- ☒ Program Coordinator
- ☐ Direct – Part time
- ☐ Volunteer
- ☒ Clinical Director
- ☐ Counselor Non-Licensed
- ☐ Advocate
- ☐ Nurse – Full time
- ☐ Executive Director
- ☐ Program Director
- ☐ Direct – Care Full time
- ☐ Direct – Care On-Call
- ☐ Intern
- ☐ Counselor Licensed
- ☐ Case Manager
- ☒ Human Resources
- ☒ Nurse – Part time
- ☒ Chief Operating Officer
- ☒ Program Manager
- _____ # Case Managers
- **2** # Program Supervisors
- _____ # Food Service Personnel
- _____ # Healthcare Staff
- _____ # Maintenance Personnel
- _____ # Other (listed by title): _____

Documents Reviewed

- ☐ Accreditation Reports
- ☒ Affidavit of Good Moral Character
- ☒ CCC Reports
- ☒ Logbooks
- ☐ Continuity of Operation Plan
- ☐ Contract Monitoring Reports
- ☐ Contract Scope of Services
- ☒ Egress Plans
- ☒ Fire Inspection Report
- ☐ Exposure Control Plan
- ☒ Table of Organization
- ☐ Fire Prevention Plan
- ☒ Grievance Process/Records
- ☒ Key Control Log
- ☒ Fire Drill Log
- ☒ Medical and Mental Health Alerts
- ☒ Precautionary Observation Logs
- ☒ Program Schedules
- ☐ Supplemental Contracts
- ☐ Telephone Logs
- ☒ Vehicle Inspection Reports
- ☐ Visitation Logs
- ☒ Youth Handbook
- **0** # Health Records
- **4** # MH/SA Records
- **20** # Personnel /Volunteer Records
- **8** # Training Records
- **8** # Youth Records (Closed)
- **6** # Youth Records (Open)
- **1** # Other: **1**

Surveys

- **3** # Youth
- 6 # Direct Care Staff
- **0** # Other: _____

Observations During Review

- ☐ Intake
- ☐ Program Activities
- ☐ Recreation
- ☐ Searches
- ☒ Security Video Tapes
- ☐ Social Skill Modeling by Staff
- ☐ Medication Administration
- ☒ Census Board
- ☒ Posting of Abuse Hotline
- ☐ Tool Inventory and Storage
- ☐ Toxic Item Inventory and Storage
- ☐ Discharge
- ☐ Treatment Team Meetings
- ☐ Youth Movement and Counts
- ☒ Staff Interactions with Youth
- ☒ Staff Supervision of Youth
- ☒ Facility and Grounds
- ☐ First Aid Kit(s)
- ☐ Group
- ☒ Meals
- ☒ Signage that all youth welcome

Comments

Additional Comments regarding observations, other important findings of interest, etc.

Strengths and Innovative Approaches

Rating Narrative

The Chief Executive Officer and Leadership Team of Crosswinds is currently working to re-organize its organizational structure and providing various training to all direct staff.

The agency is capturing all activities, events, and shelter operations information in the digital logbook platform.

Crosswinds is adding new positions that include 1 Lead and a Program Manager.

The agency researched and has made a decision to utilize the Berke Assessment Tool during to determine the suitability of prospective candidates during its hiring process.

Crosswinds is receiving Dale Carnegie Training.

Crosswinds is instituting a pay increase for all Direct Care Workers.

Standard 1: Management Accountability

Overview

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 direct day-to-day services and activities of both the residential and the non-residential CINS/FINS Program. Specifically, Crosswinds staff includes: Program Mangers, Clinicians, Counselors, Lead Youth Care workers, and fifteen full and part-time Youth Care Workers. At the time of this onsite Quality Improvement program review, the agency had several vacant Youth Care Worker positions. The agency has an Annual Training Plan for their personnel that includes the core topics that are required by their FNYFS contract, DCF licensure, as well as their own list of required training topics. These training topics are developed and scheduled to allow all of the agency's new hires, on-going and part-time staff members to meet the first 120 days, annual and on-going training requirements. Crosswinds continues to maintain an individual employee training file that contains supporting documentation for training topics and hours completed by each staff member. Crosswinds has established interagency agreements with several local schools, community-based organizations, government, and other non-profit agencies.

The agency also reports that they are working to address several major incidents and program staffing and operations issues. The agency is reporting they are working to fill vacant direct care positions. The program reports that they are implemented using the Berke Assessment effective 7/24/19 for suitability assessment screening as part of the hiring process.

Standard 2: Intervention and Case Management

Overview

Crosswinds is contracted to provide both temporary residential services for youth 10-17 years old for residential services and non-residential services 6-17 years old of age and their families residing in Brevard County. Crosswinds provides counseling and coordination for case management services through residential and non-Residential Counselors. The program provides comprehensive centralized screening and intake to determine eligibility for referrals twenty-four hours per day. If a youth is determined to be eligible, the agency conducts an intake and assessment. Following the completion of an intake and 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 youth and family to implement the case plan. Counselors document progress towards completion or non-completion of the service plan goals outlined in the plan. Crosswinds does provide Case Staffing Committee and participates in the CINS petition process. The agency also operates a Stop Now and Plan program to serve families in Brevard County.

Standard 3: Shelter Care

Overview

Crosswinds provides temporary emergency residential services 24 hours a day, 7 days a week, for eligible youth primarily 10-17 years of age. The youth shelter is licensed by the Department of Children and Families (DCF) for twenty-eight (28) beds and provides residential services to youth in the Department of Juvenile Justice (DJJ) CINS/FINS program and emergency placement youth from the 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. Agency uses a daily activities schedule to service youth. Direct care youth worker staff members are responsible for conducting all admission related services for the youth, including orientation and tour of the shelter, and for conducting day-to-day activities with the youth. The agency uses 15-20 full and part-time staff members to operate the youth shelter twenty-four hours a day.

Standard 4: Mental Health/Health Services

Overview

Crosswinds Youth Shelter conducts admission screening for eligibility, intake, classification, and assessment services to fulfill the safety and appropriate supervision requirements to serve 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. 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 also ensures staff members received first aid training. The agency also utilizes staff members that are licensed clinical professionals that oversee the clinical program and services provided to clients. Specifically, the agency has two (2) licensed clinicians and a part-time registered nurse. 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 nursed that are authorized to distribute medication to residents during their shelter stay. The agency also utilizes a Pyxis MedStation 4000 medication cart to secure and manage all controlled, non-controlled and over the counter medication. The agency uses an alert system that includes a medical and mental health alert function to inform staff on the status of all residents in the facility.

STANDARD 1: MANAGEMENT ACCOUNTABILITY

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
Standard One – Management Accountability							
1.01: Background Screening and compliance with DJJ OIG statewide procedures regarding BS of employees, contractors and volunteers							
Provider has a written policy and procedure that meets the requirement for Indicator 1.01						☒ YES ☐ NO (explain) The program has a policy and procedures (P&P) titled Background Screening, which meets all requirements of the Background Screening of Employees/Volunteers indicator. The P&P was reviewed and signed by the program's CEO August 2019.	
RATING	☐	☒	☐	☐	☐	The Affidavit of Annual Compliance with Level 2 Screening Standard was completed and submitted to the Background Screening Unit on January 1, 2019. The program began to utilize the BERKE Assessment Instrument July 24, 2019; however, the process took approximately two weeks to begin. Of the fourteen staff reviewed, five were hired prior to July 1 and not applicable for completing the pre-employment assessment. Of the nine staff applicable to complete the BERKE, eight did so.	**Exceptions** Of the nine applicable staff files reviewed, one staff did not complete a Pre-employment Assessment. Staff (1 staff was hired on 7/29/19 – after 7/1/19)

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						Fourteen new hire files were reviewed. Each of the files contained a completed background screening that was completed prior to each new hire's start date. None of the files reviewed were rated ineligible. All fourteen staff files documented an E-Verify was completed. Six staff were eligible for five-year rescreening. Of the six files reviewed, all documented a completed five-year rescreen; however, one was completed too early.	
1.02: Provision of an abuse free environment to ensure safety and abuse free environment for youth in care							
Provider has a written policy and procedure that meets the requirement for Indicator 1.02						☒ YES ☐ NO (explain) The program has a policy and procedures addressing Employee Conduct and Ethics, Grievances, Abuse Reporting by Staff and Abuse Report by Client. The P & P was reviewed and signed by the program's CEO August 2014. The program has a policy and procedures which addresses their process for all youth grievances. The P & P was reviewed and signed by the program's CEO July 2018.	
RATING	☒	☐	☐	☐	☐	Their policy indicates all employees must adhere to the program's code of ethics. Throughout the program and shelter there is signage to reflect all youth are accepted and postings of the Florida Abuse Hotline number. The program utilizes a Critical	No exceptions.

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						Incident Reporting Form to document any call to the Florida Abuse Hotline. Reviewed seventeen CCC reports for the last 6 months along with the accompanying incident reports. Of the seventeen, one incident was required to be reported to the Florida Abuse Hotline and was completed and conducted as required. The shelter maintains a grievance box, which is locked and is checked daily by the clinical director or shelter manager. The clinical director and shelter manager were interviewed and indicated shelter staff do not handle youth grievances. The program maintains all youth grievance for a minimum of one year. Reviewed twenty-five youth grievances. All reviewed grievances confirmed staff reviewed each grievance filed. The following deficiencies were observed but they did not result in exceptions. Of the twenty-five, three were reviewed after the 72-hour timeframe. 2 Youth submitted grievances on 2/8/19 and they were reviewed by staff on 2/12/19, which is outside of the 72-hour timeframe requirement.	

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						Youth submitted grievance on 2/11/18 or 2/14/18 (did not indicate 2019 but specifically written as 2/14/18) and reviewed by staff on 2/18/19.	
1.03: Incident Reporting							
Provider has a written policy and procedure that meets the requirement for Indicator 1.03						☒ YES ☐ NO (explain) The program has a policy and procedures which addresses their process for all incident reporting. The P & P was reviewed and signed by the program's CEO November 2018.	
RATING	☐	☒	☐	☐	☐	The program utilizes three separate reporting forms, depending on the type of incident, which are the Incident Report, Central Communications Center Incident Report and Critical Incident Reporting Form. Reviewed seventeen CCC reports along with the accompanying incident reports. An incident report was completed for fifteen of the reviewed CCC reports. Of the seventeen CCC reports, five were reported late (after the required 2-hour timeframe). Of the seventeen CCC calls, only three were entered in the program logbook. The incidents surrounding the incident are noted in the logbook. (this is captured in 3.04). Each of the seventeen incident reports were signed by program management.	**Exception** Two incident reports were not completed, and one incident was completed late: •7/10/19 (staff arrest) – staff was terminated; however, according to program staff an incident report was not completed. •8/26/19 (staff arrest) – incident report completed on 11/11/19. •9/1/19 (hurricane evacuation) The program maintained a folder of the evacuation process; however, according to program staff an incident report was not completed The following CCC reports were completed over the two hours: •6/22/19 (7 hours & 19 mins) •8/15/19 (4 mins) •10/7/19 (13 hours) •9/27/19 (12 mins) •10/26/19 (46 mins)

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		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						While onsite, an incident of falsification regarding bed checks was determined and it was reported to the CCC within the 2-hour timeframe. Program management indicated the staff will have to resign or will be terminated.	Of the seventeen CCC reports, only able to locate three in the program's electronic logbook. An entry in the electronic logbook for CCC report date of 9/14/19 was entered and indicated the CCC was called and a message was left, however, there was not a follow up entry. The CCC date of 9/20/19 was recorded in the logbook late (9/24/19).
1.04: Training Requirements **Staff receives training in the necessary and essential skills required to provide CINS/FINS services and perform specific job functions**							
Provider has a written policy and procedure that meets the requirement for Indicator 1.04						☒ YES ☐ NO (explain) The program has a policy and procedures which addresses their process for all training requirements and was reviewed and signed by the CEO.	
RATING	☐	☒	☐	☐	☐	The program maintains an individual training file for each staff member, which captures the training topics, hours, certificates, sign-in sheets, and agendas. Reviewed four pre-service (new hire) staff training files. All four staff completed their training hours, which are required within 120 days of hire with the exception of two staff. In addition, all four staff completed some of the training late, after 120 days of their hire date. Of the four staff, two of the staff have completed all training required within the first year and only two have five trainings	**Exceptions** Unable to locate documentation for 2 of 4 staff files the following staff completed the training which is required within the first 120 days of hire. 3 of 4 staff did not have evidence of Program Orientation training, however, 2 staff were reported to be re-hires during a follow-up interview with program staff. 1 new hire staff had no evidence of program orientation in file. The following 4 staff completed the required training; however, did not

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		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						left and one training left respectively; however, all four are still within their first year of hire. A review of four in-service training files, validated all four staff completed the required training with the exception of Suicide Prevention Training for three staff and Human Trafficking for all four staff. One staff training record was reviewed for verification Assessment of Suicide Risk (ASR) training was completed. The staff was hired on September 30, 2019 and completed the ASR training on October 22, 2019. The LMHC signed off on the five observed assessments, which were completed by the staff. The training documentation validated the staff received 20 hours of training in ASR, mental health crisis intervention, and emergency mental health services.	complete it within 120 days of hire timeframe: Staff 1(due 9/13/19) •Crisis Intervention (completed on 11/6 & 11/7) Staff 2 (due 9/17/19) •Crisis Intervention (completed on 11/6/19 & 11/7/19) •SkillPro Suicide Prevention Part 1 (completed on 11/14/19) •Mental Health and substance Abuse (completed on 11/10/19 & 11/14/19) •Behavior Management (completed on 11/7/19) •CPR/first aid (completed on 10/22/19) •Universal Precautions (completed on 11/14/19) Staff 3 (due 6/18/19) •Crisis Intervention (completed on 11/6/19 & 11/7/19) •Suicide Prevention (3 hours completed on 11/20/19) •Universal Precautions (completed on 11/20/19) Staff 4 (due 6/18/19) •Crisis Intervention (completed on 11/6/19 & 11/7/19) •Suicide Prevention (3 hours completed on 11/20/19) •CINS/FINS Core (completed on 7/24/19)

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
							•CPR/first aid (completed on 10/22/19) Unable to locate training for the following 4 staff for annual requirements: Staff 1 •Human Trafficking 101 Staff 2 •Human Trafficking 101 •Suicide Prevention Training Part 2 Staff 3 •Human Trafficking 101 •Suicide Prevention Training Part 1 and Part 2 Staff 4 •Human Trafficking 101 •Suicide Prevention Training Part 2
1.05: Analyzing and Reporting Information **The program collects and reviews several sources of information to identify patterns and trends. Program should have sample reports of aggregated data and committee/workgroup minutes analyzing information.**							
Provider has a written policy and procedure that meets the requirement for Indicator 1.05						☒ YES ☐ NO (explain) The agency has policies 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 in November 2018. The agency policies are focused on the agency's approach to executing, analyzing and reporting the policy and procedures for analyzing and reporting data for the following areas including record reviews,	

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		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						incidents, accidents, grievances, customer satisfaction, and outcome data.	
RATING	☐	☒	☐	☐	☐	The agency has a PQI Committee that is primarily responsible for executing the review of program operations and program contract requirements 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. 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. Specifically, the agency's COO reviews incidents on a monthly basis to review the agency's practice of how it responds to risk management issues. The agency reported that it uses and conducts regular quality checks of it's programs and services provided to clients. The agency reported that is does this by conducting client case file record reviews on a monthly basis for accuracy and completion. The agency did produce	**Exceptions** The agency has experienced a series of reportable incidents in staff members and residents. The incidents within the last 6 months include staff members not abiding by moral, character and work performance standards. The incidents do not have detailed evidence of the agency's active process that demonstrates their internal capability for identifying and detecting program service and operational issues. Additionally, the agency does not have significant information or evidence how it addresses workplace performance issues and how these issues are assessed. Further, these incidents indicate some degree of lack in proper internal controls or the ability of management to identify weaknesses in staffing and operations. The recent series of work issues over the past several months also indicates that the agency is challenged in its ability to identify improvements, implement corrective actions that would address substandard issues or the proper measures needed to modify and improve any unacceptable workplace performance concerns of its staff members and various incidents.

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		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						examples of some of the aforementioned reports.	
1.06: Client Transportation **Policy is established to avoid situations that put youth or staff in danger of real or perceived harm, or allegations of inappropriate conduct by either staff or youth.**							
Provider has a written policy and procedure that meets the requirement for Indicator 1.06						☐ YES ☒ NO (explain) The agency has a Section 5-12, Transportation of Youth, policy that was last revised on February 2019 and approved by the agency President/CEO.	The policy does not clearly indicate that the supervisor will be aware **prior** to a single transport taking place to provide approval as required per the QI standard.
RATING	☐	☒	☐	☐	☐	The program has recently revised the transportation form and the form includes the following information: date, destination, driver, beginning/ending mileage, start/end times, passengers, comments, and now includes a section for program so that when the van is used for other youth besides CINS/FINS it is clearly indicated. Transportation logs were reviewed as follows: Van #1 – KMSG04 Dates ranged from 10/30/19 - 11/20/19 Van #2 - KMRK67 Dates ranged from 10/23/19 – 10/4/19; 7/5/19-4/25/19 Van #3 – KMQW95 Dates ranged 11/12/19 – 5/21/19 16 single transports In review of the logs, it was identified that some logs were completed consistently,	**Exceptions** Observed that the form is not consistent in completing the form in its entirety. Per FN and agency procedure, the purpose of travel and location should be documented. Practice is inconsistent with completion on forms across all vehicles and do not include both purpose and location. Additional observations of the transportation log noted that some staff include youth names and some lines are skipped to possibly allow staff to go back and enter a missing log entry (based on the mileage numbers not being sequential). The practice is unclear when this comment section is consistently used and unable to clarify based on procedure what expectation is for staff to complete form. Director of Counseling Services has provided permission for several of the single transports; however, staff are

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		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						however, there was some inconsistency in complete documentation and utilization of the form. There were dates, program information, number of passengers, the destination, or purpose of travel were missing throughout the logs. It was noted in comments on some entries regarding '1 staff' or '1 adult' but it was unclear when if the 'adult' was an approved third-party intern or volunteer. The comment section is used to indicate 'adult or staff' inconsistently and whether there is '0 passengers - 6 passengers', which does not provide clarification on whether this adult is an additional passenger to the driver. In speaking with the program manager, the comment section should be only be used to note when an additional staff is accompanying the driver. Reviewed 9 staff files for a valid Florida driver's license. 1 staff had a license from Alabama that expires in 4/2022 but she was hired on 11/18/19, therefore, this was not considered to be a deficiency as the program stated the staff member would not transport and would be obtaining a FL driver's license.	advised to document this and staff are not consistently documenting these in the program log to verify that supervisor approval is provided prior to transport. Staff are not using one line to cross out information when making changes to the log. Policy doesn't specify how the comment section on the form is to be used so staff and this reviewer is unable to verify or validate what the agency is using as the preferred practice and staff interviewed report different interpretations of what is needed in that section.
1.07: Outreach Services **The agency participates in local DJJ board and council meetings to increase public safety by reducing juvenile delinquency through effective prevention, intervention and treatment services and ensure CINS/FINS services are represented in a coordinated approach.**							

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		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
Provider has a written policy and procedure that meets the requirement for Indicator 1.07						☒ YES ☐ NO (explain) Crosswinds Public Awareness and Targeted Outreach Services policy was last updated and reviewed by the agency 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. The policy was approved and signed by the President/CEO.	
RATING	☒	☐	☐	☐	☐	The COO requires that 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 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 agency COO reported that the agency regularly attends local DJJ council meetings,	There were no exceptions noted for this indicator.

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		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						facilitates and participates in joint system partner staffings as needed. The agency also markets and promotes its core residential and non-residential services and other specialized offerings throughout Brevard County and to the general community. The agency is also engaged in multiple partnerships utilizing various methods including newsletters, local paper, agency website, and social media platforms such as Facebook. The reviewer was provided documentation of meetings attended and outreach efforts by the agency from July 2019 – November 2020. Additionally, the agency has staff members that regularly attend DJJ Advisory Board meetings. The agency and minutes are maintained in a binder that was provided during the onsite QI program review. The agency conducts various charitable fundraisers that include the annual Duck Race.	

STANDARD 2: INTERVENTION AND CASE MANAGEMENT

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
Standard Two – Intervention and Case Management							
2.01: Screening and Intake							
Provider has a written policy and procedure that meets the requirement for Indicator 2.01						☒ YES ☐ NO (explain) The provider's policy and procedure policy for screening and intake (2-02) Shelter & Non-residential Services combined) was dated effective November 1,2004, with the most recent revision date being November 2018. Policies related to this indicator are as follows: 2.01 - 24 Hour Access 2.03 - Needs Assessment The policy was approved and signed. All requirements of this indicator are addressed within this policy.	
RATING	☒	☐	☐	☐	☐	A total of ten (10) files were reviewed Non-residential - two (2) open files, three (3) closed. Residential - two (2) open three (3) closed files were reviewed. All files included screenings completed within the required timeframe, the handbook (Res. & Non-Res) is shared with each youth and family and there is documentation that the book is received. Both handbooks include service options and possible actions. The grievance policy is included on the Client	No exceptions.

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						Information/Rights and responsibilities form.	
2.02: Needs Assessment							
Provider has a written policy and procedure that meets the requirement for Indicator 2.02						☒ YES ☐ NO (explain) The provider's policy and procedure policy for Needs Assessment (2-03) Shelter & Non-residential Services combined) was dated effective November 1,2004, with the most recent revision date being August 2014. The policy was approved and signed. All requirements of this indicator are addressed within this policy.	
RATING	☐	☒	☐	☐	☐	A total of ten (10) files were reviewed. Non-residential - two (2) open files, three (3) closed. Residential - two (2) open three (3) closed files were reviewed. Eight (8) of the ten (10) files included Needs assessments that contained all elements required by the Florida Network. Four (4) of the five (5) residential files reviewed were initiated within 72 hours of admission. Four (4) of the five (5) non-residential files reviewed were initiated within 2-3 visits/sessions. All eight (8) files were signed by Master level counselors and reviewed by Licensed counselors. It was observed that Supervisors signing off on documents they completed did not always have evidence this was reviewed by the next level supervisor/director.	**Exceptions** A non-residential Case Staffing file reflected that there was some discrepancy with dates for the screening, Needs assessment, and chrono notes. A note written by the counselor stated that the Needs Assessment was not completed due to lack of communication because of summer vacation. One Residential file had no Needs Assessment, this was noted on the form entitled "Counseling Service Record", also that the counselor was terminated. One Non-residential file had no Needs Assessment.

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
2.03 Case/Service Plan							
Provider has a written policy and procedure that meets the requirement for Indicator 2.03						☒ YES ☐ NO (explain) The provider's policy and procedure policy for Service Planning (2-04) Shelter & Non-residential Services combined) was dated effective November 1,2004, with the most recent revision date being August 2014. The policy was approved and signed. All requirements of this indicator are addressed within this policy.	
RATING	☐	☒	☐	☐	☐	The agency utilizes two different service plans for residential and non-residential cases. The service plans contain all required elements listed in the required indicator such as type, location and frequency of service, person responsible, target date for completion, completion dates and signature from all involved parties. The procedures indicate the case manager/counselor shall review the service plan every 30 calendar days for the first 3 months the youth is in CINS/FINS program and every six months thereafter, and that case records document all efforts to engage and include the family/guardian or designated others in the service plan. The program has a process for a case/service planning in that it is	**Exceptions** Two (2) (residential) of the ten (10) files reviewed in this indicator did not have youth signatures Three of the parent signatures were missing.

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						developed with the youth and the family within seven (7) working days following the completion of the needs assessment. The Case Plan is developed based on the information gathered during the initial screening, intake, and assessment. Four of the five non-residential files were eligible for case plan implementation and they were in place. The one file was a case staffing file, in which the committee recommendations served as the case plan, as the family no longer engaged with the counselor for therapy. Each of the four service plans were completed timely. Each consistently included individualized goals, service type, frequency, and location as well as person(s) responsible, and target dates. Two youth signatures were not present, however, the parent, counselor/ case manager and supervisor were there with the same initiation date. Two of the four files had a 30 and a 60-day service plan review completed with all signature's present youth, parent, counselor, supervisor. Three of the four Residential files were eligible for case plan implementation and a service plan was implemented. The service plans included individualized goals congruent with needs identified in the Needs Assessments. Each of the plans listed type, frequency, location, persons responsible, and target date. None of the plans indicated that the goals were	

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						completed as of the date of the QI review, however, there were notes indicating that the youth made progress. Each of the plans had the youths' signatures as well as signatures of the counselor and supervisor; one of the four had parent signatures.	
2.04: Case Management and Service Delivery							
Provider has a written policy and procedure that meets the requirement for Indicator 2.04						☒ YES ☐ NO (explain) The provider's policy and procedure policy for Case Management & Service Delivery are presented in two separate policies (2-05 - Services & 2-06 - Case Management) Shelter & Non-residential Services combined) was dated effective November 1,2004, with the most recent revision date being August, 2014. The "Services" policy (2.05) outlines various services offered, such as Parenting Classes, Cultural Arts classes, Substance Abuse and Mental Health Treatment. The policy was approved and signed. The policy and procedure addresses all of the key elements of this indicator.	
RATING	☒	☐	☐	☐	☐	The assigned counselor serves as case manager and is responsible for coordinating the delivery of services both internally at the agency and externally in the community via referrals. Referrals are evident in all of the non-residential cases reviewed and are documented in the client's case file. However, case	No exception.

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		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						management activities are scarce in the residential files. Of the residential files reviewed the youth had services in place prior to admission to the program, thus, the coordination of continued services were evident. However, there were no instances where a youth was referred by the agency to receive services that would benefit the youth. The following services were present in more than 50% of the cases reviewed. -Coordinated service plan implementation -Provided supportive services to the family -Recommend and pursued judicial intervention in selected cases -Accompanied youth and parents to court hearing and related appointments, if applicable -Made referral for additional services, if needed -Monitored out of home placements (none of the files applied) -Continued case monitoring and review including court orders. There were no closed cases reviewed that meet the requirements to assess that youth were provided case termination and follow-up.	
2.05: Counseling Services							
Provider has a written policy and procedure that meets the requirement						☒ YES ☐ NO (explain)	

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
for Indicator 2.05						The provider's policy and procedure policy for Counseling (2-07) Shelter & Non-residential Services combined) was dated effective November 1,2004, with the most recent revision date being August 2014. The policy was approved and signed. All requirements of this indicator are addressed within this policy. The agency has a written policy and procedures in place to ensure that youth and families receive counseling services in accordance with the needs identified during the assessment process.	
RATING	☐	☒	☐	☐	☐	A total of ten (10) files were reviewed. Non-residential - two (2) open files, three (3) closed. Residential - two (2) open three (3) closed files were reviewed. The Youth and families are offered counseling services in accordance with the youth's case/service plan. The case/service plan addressed the needs identified during the assessment process, including issues related to substance abuse, mental health, and suicide risks. The program maintained chronological notes on the youth's progress. The program maintains individual case files on all youth and adheres to all laws regarding confidentiality. The program also maintains an on-going internal process that ensures clinical review of case records, youth management, and staff performance regarding CINS/FINS. However, it is recommended that the	**Exception** There is evidence of Group counseling, but in the residential files reviewed, documentation was sporadic, days of notes missing and no documentation as to why the youth didn't attend or groups were not conducted as required (5 days per week). Inconsistent documentation for residential client file reviews (none completed since June 2019).

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		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						reviews are done more frequent and consistent for both the residential and non-residential programs. There was some evidence that Supervisors reviewed the case records as evidenced by signed needs assessments, treatment plans or as per the counselor's documentations at the 30/60/90 review dates, however the practice was inconsistent. The shelter offers individual/family counseling services. Counselors meet with the youth as planned and if the youth or caregiver were not available, or canceled, documentation in the progress notes were noted. It was observed that Non-licensed counselors do not consistently include their credentials. The program provides different types of groups; Health/Abstinence, Anger Management, Substance Abuse, Life Skills, and open discussion groups. The Quality Improvement Youth Survey reflected that the youth reported having a counselor. The youth stated yes to their counselors asking them what they wanted to do while in the shelter and also reported knowing what goals they were currently working on.	
2.06: Adjudication/Petition Process							
Provider has a written policy and procedure that meets the requirement for Indicator 2.06						☒ YES ☐ NO (explain) The provider's policy and procedure for Adjudication/Petition Process, entitled	

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						Case Staffing Committee (2-10) (Shelter & Non-residential Services combined) was dated effective November 1,2004, with the most recent revision date being August 2014. The policy was approved and signed. All requirements of this indicator are addressed within this policy. The policy was approved and signed by the President/CEO.	
RATING	☐	☒	☐	☐	☐	A total of three (3) open and two (2) closed residential files were reviewed. A total of three (3) open and two (2) non-residential files were reviewed, for a total of 10 files reviewed. The procedures explained that a referral to the case staffing committee is needed to address the problems and needs of the youth/family when 1) The family or youth does not participate in the services such as, school compliance, family rules & regulations, etc. 2) The family or youth is not in agreement with the services or treatment offered, or 3) The Department of Juvenile Justice or Crosswinds CINS/FINS Case Manager receives a written request from the parent /guardian or any other member of the committee. The Case Staffing Committee process is very active, useful, and productive in the CINS/FINS service delivery process. The committee has more than five standing members and additional participants may attend if requested by the agency or the family. Meetings are held twice a month at	**Exception** There was no evidence that committee members were notified no less than 5 working days prior to the meeting.

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		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						the agency site on Fridays and several cases are presented by the assigned counselor/case manager and are staffed at each meeting. The exception to this schedule is made when a parent/guardian submits a written request for immediate intervention within seven (7) days (excluding weekends and holidays) after the receipt of a written request from a parent/guardian. One Case Staffing file was reviewed. This case was referred to the program by the school. Notification was made to the parent with no less than 5 days prior to convening the meeting. The file reflected that the youth's service plan is updated at the time of the Case Staffing with new/updated service recommendations and notes about what took place in court. In one file, the updated service plan with recommendations was given to the parent it was signed and dated, and a copy was given that day.	
2.07: Youth Records							
Provider has a written policy and procedure that meets the requirement for Indicator 2.07						☐ YES ☒ NO (explain) The provider's policy and procedure for Counseling/Youth Records (2-07) Shelter & Non-residential Services combined) was dated effective November 1,2004, with the most recent revision date being January 2019. Policies related to this indicator are	The Florida network requirement regarding files being kept in a neat and orderly manner should be included in the agency's "Youth Records" policy.

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						as follows:1.09 - Confidentiality and 1.10 - Client Record Management. The policy was approved and signed by President/CEO.	
RATING	☒	☐	☐	☐	☐	The agency has a written policy and procedure that address all of the key elements of this indicator. The program has a process for maintaining youth records. The policy and procedures offer the youth with an individual file, chronological notes on the youth's progress, and provides ongoing internal case review/case monitoring that ensures clinical review of the case records. A total of three (3) open and two (2) closed residential files were reviewed. A total of three (3) open and two (2) closed non-residential files were reviewed, for a total of ten(10) cases. All 6 records were marked confidential. All records are kept in a secure room or locked in a file cabinet, marked confidential and all records are maintained in a neat and orderly manner. In the residential shelter facility, all client case files are stored securely in a file cabinet near the Shelter Manager's office behind a locked door. Access is limited to authorized staff and is primarily utilized by the assigned counselor/case manager. In non-residential services client case files are stored in a locked, secure file room with access limited to the assigned	No exception.

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						counselors/case managers and authorized staff. All files are marked The agency has a written policy and procedure that address all of the key elements of this indicator. The program has a process for maintaining youth records. The policy and procedures offer the youth with an individual file, chronological notes on the youth's progress, and provides ongoing internal case review/case monitoring that ensures clinical review of the case records. All ten (10) case files were marked confidential. All records are kept in a secure room or locked in a file cabinet, marked confidential and all records are maintained in a neat and orderly manner. In the residential shelter facility, all client case files are stored securely in a file cabinet behind a locked door. Access is limited to authorized staff and is primarily utilized by the assigned counselor/case manager. In non-residential services client case files are stored in a locked, secure file room with access limited to the assigned counselors/case managers and authorized staff. All files that are transported are stored in an opaque mobile box, locked, and marked confidential.	
2.08: Sexual Orientation, Gender Identity, Gender Expression							

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
Provider has a written policy and procedure that meets the requirement for Indicator 2.08						☒ YES ☐ NO (explain) The provider's policy and procedure Section 3-34 for Sexual Orientation, Gender Identity, and Gender Expression was dated effective July 2018. The policy was approved and signed by the President/CEO.	
RATING	☐	☒	☐	☐	☐	The agency had appropriate signage located in common areas indicating that all youth are welcome. Including signs that the youth have designed themselves using the 'rainbow' symbols and the pictures are hung and decorate the facility. 1 closed file reviewed met this indicator requirement. The file only referenced the gender and pronouns that would be related to the youth's birth certificate, however, the file indicated in the referral and intake process that this youth identified as transgendered. Upon interview with shelter manager it was explained that the youth would often switch and change their preferred gender identity, however, this was not documented in progress notes or anywhere in the file to reflect the youth changing their status during their length of stay. Per an interview with staff, it was explained that youth are provided hygiene	**Exception** The 1 closed file reviewed did not reflect that the youth's preference was taking into consideration for outward facing documents and that the youth is addressed according to their preferred pronouns. There was missing evidence to support that policy 5.08 is provided and staff/providers and volunteers have knowledge of the requirements of this policy.

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		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						products or undergarments based on what they request which adheres to the policy requirement to affirm the gender identity or gender expression that the youth chooses. Staff surveyed varied on how they would address SOGIE youth. 2 out of 4 would go by birth certificate.	
2.09: Special Populations							
Provider has a written policy and procedure that meets the requirement for Indicator 2.09						☐ YES ☒ NO (explain) The provider's policies and procedures for Special Populations are covered in the following policies: Section 3-31 for Domestic Violence Respite; DMST 3-32; Probation respite 3-33; FYRAC 3-35 which was last revised on November 2018. The policy was approved and signed by the President/CEO**.**	DV and PR Policies need to include all verbiage in accordance with FN QI standard requirements. For example, the following was noted to be missing... data entry into NetMIS and JJIS within 24 hours of admission and 72 hours of release. Youth length of stay in DV respite placement does not exceed 21 days.
RATING	☒	☐	☐	☐	☐	3 files were reviewed for this indicator. 1 open and 2 closed files met the domestic violence requirement criteria. All 3 files reviewed met the criteria for evidence of being detained for DV charges and none of the youth had a stay longer than 21 days. 1 out 2 closed files indicated that data entry into Netmis was within 24 hours of entry and 72 hours of release. 1 open file indicated the data entry was within 24 hours as required.	**Exceptions** The data entry for 1 out of 2 closed files was outside of the 72 hour timeframe as required. All 3 files did not meet the CINS FINS requirements of the needs assessment being completed within the 72 hour timeframe to meet the consistency of the CINS FINS program requirements.

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						2 files case plan were reviewed and showed evidence of goals that reflect focusing on aggression management and family coping skills. 1 youth case plan was unavailable for review due to the file being used for meetings to address their service provision. All 3 files did not have a youth exceeding 21 days of stay. 1 youth is at day 21 today but was in a meeting to be transferred to non-res services.	
2.10: STOP NOW AND PLAN (SNAP)							
Provider has a written policy and procedure that meets the requirement for Indicator 2.10						☐ YES ☒ NO (explain) The president/CEO or designee has signed off on the following policies effective 11/1/17: 6.1 SNAP Program Delivery 6.2 SNAP Fidelity Adherence Monitoring 6.3 SNAP Intake Requirements 6.4 SNAP Discharge Requirements 6.5 SNAP in Schools (effective June 2017)	There is no approval or review date next to the signature. Policy 6.5 does not capture all of the indicator requirements regarding the forms to be completed as required.
RATING	☐	☒	☐	☐	☐	The program states that they provide transportation to SNAP clients provided by Crosswinds shelter YCW staff. The program expressed challenges with teacher's that do not typically stay for any of the SNAP in School sessions so the librarian has to sign off on the 'Shoot for Your Goals' sheets and the session attendance logs.	**Exceptions** 1 out 3 files did not have consent signed by guardian which is required prior to receiving services per FN policy. 2 closed files were missing the NEEDS Assessment at intake and missed evidence this was completed within the required timeframes.

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						3 files reviewed for SNAP Clinical (1 open and 2 closed) and 1 SNAP in Schools reviewed. SNAP Clinical findings: All 3 files included NETMIS screening form and SNAP Brief intake form. 1 out of 3 NETMIS screening forms contained the supervisor signature that these were reviewed. 1 out of 3 files had the Needs assessment. 2 out of 3 files reviewed (1 open, 1 closed) did have consent from parent to participate in services. All applicable files contained the Pre – PAT assessments and Post PAT assessments. 8 out of 8 SNAP Facilitator Training certifications were reviewed. The program shared the challenges with the school having a majority of Spanish speaking students that cannot write due to the English limitations and their age for approximately 50% of the population they are serving. The Supervisors states that they have requested Spanish translated forms from the FN in September but currently only have limited staff available to facilitate classes to these youth.	2 out of 3 NETMIS screening forms missed the supervisor signature that these were reviewed. 1 out of 3 missed supervisor signatures for CINS FINS Intake form. 3 out of 3 Snap in Schools reviewed have completed up to session 10 but still did not have the Pre evaluations for youth or pre-evals for teachers. Supervisor shared challenges in obtaining these from teachers since original request made at beginning of school year on 9/11/19 via email correspondence. 2 out 2 closed files - Post CBCL, TOPSE, and TRF are not evident in the files but there was no explanation in the file regarding why this was missing. 2 out 3 files did not contain the PRE TRF, or TOPSE in the files. 10-week sessions reviewed for 3 classes. Bauman class missing attendance session 6, Hickman/Smith missing 3rd session teacher sign off. Closed files did not contain the following required documents: SNAP Discharge summaries, TOPSE Pre or Post assessments, Post – CBCL, Post - TRF.

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		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						It was observed that the agency's internal policy notes anger/violence evaluation will be completed with all youth but this was not noted in any files.	1 closed also missed both Pre/Post TRF.

STANDARD 3: SHELTER CARE

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
Standard Three – Shelter Care							
3.01 Shelter Environment **The shelter's environment is safe, clean, neat, and well maintained. The program provides structured daily programming to engage youth in activities that foster health, social, emotional, intellectual, and physical development.**							
Provider has a written policy and procedure that meets the requirement for Indicator 3.01						☒ YES ☐ NO (explain) The agency has a written policy and procedure Shelter Environment that addresses all elements of the QI indicator. The policy was last revised in August 2014 and was approved by the President/CEO.	
RATING	☒	☐	☐	☐	☐	An inspection of the shelter environment was conducted during a tour of the facility. The furnishings appeared to be in good repair. There was no visible graffiti on walls, doors, or windows. The bathroom and shower area were clean and functional. The program was free of insect infestation. The grounds were landscaped and well-maintained and the exterior appeared to be free of debris and hazards. The dumpster and garbage cans located in the kitchen and dining areas were covered. The lighting was adequate throughout the facility. All doors were found to be secure, and in-and-out access is limited to staff members with keys. All interior areas were observed to be free from contraband and unauthorized metal/foreign objects.	No exceptions

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		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						All youths' beds were dressed with a clean covered mattress, pillow, sufficient linens, and blanket. There are red lockers located in the dining area that allows youth to have a safe, lockable place to keep personal belongings, and only staff has access to those keys. Three company vehicles were inspected. All vehicles were clean and free of graffiti. All three vehicles contained first aid kits and fire extinguishers. Detailed maps and egress charts are posted throughout the shelter. Postings of the Florida Abuse Hotline were also observed. The grievance forms were located in the front reception area next to the locked grievance box. The DCF Child Care License was updated February 18th, 2019 and was observed to be hanging on the bulletin board in the staff room next to the computers. All chemicals were locked in a secure storage closet. All chemicals are inventoried once a week and the sheets are kept in a binder. Safety Data Sheets for the chemicals are kept in a binder that is left in the storage closet. The Fire Inspection was conducted on January 24, 2019 and showing violations and then re-inspected on March 7, 2019	

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		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						showing the violations were corrected. Fire and Mock Emergency drills are conducted every month on each shift and kept in a binder. The Sprinkler Inspection was done on June 18, 2019, the Kitchen Hood was serviced on November 12, 2019, and the Residential Group Care Inspection was completed on January 18, 2019. The Fire Extinguisher Inspection was last conducted on November 6, 2018 as indicated by the report provided and the punch cards on the extinguishers. Update: An invoice was provided to show that the most recent Fire Extinguisher Inspection was conducted on November 14, 2019. However, the punch cards on the extinguishers still contain the previous inspection date. All cold food and dry storage appeared to be properly stored, marked, and labeled. The refrigerators and freezers appeared to be clean. The refrigerator kitchen read a temperature was 37 degrees Fahrenheit. The freezer in the kitchen thermometer read –3 degrees Fahrenheit. The freezer located in the pantry read a temperature of 0 degrees Fahrenheit. Daily programming schedules are posted throughout the shelter. Youth are provided with one hour of physical activity daily, as noted on their Daily Program Schedules. The Resident's Manual indicates that	

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		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						youth are offered faith-based actives on Tuesday evenings, Sunday mornings, and youth services on Wednesdays. Daily programming includes opportunities for youth to complete homework, as well as having two computers for youth to use to complete assignments. Youth are allowed quiet time to read and there is a library located on the second floor of the shelter.	
3.02: Program Orientation							
Provider has a written policy and procedure that meets the requirement for Indicator 3.02						☒ YES ☐ NO (explain) The agency has a written policy and procedure Program Orientation that addresses all elements of the QI indicator. The policy was approved by the President/CEO.	
RATING	☐	☒	☐	☐	☐	The files contain an orientation checklist in which staff reviews program operations with the youth. As each item is discussed, both the staff and youth initial each item. Completed checklists are then signed and dated by both parties. The files also contain a form which indicates the youth received the Crosswinds Youth Services handbook and is to be signed by both staff and youth. Three youth were surveyed. Two of the youth surveys indicated positive feedback on the orientation experience. One youth did not respond to the question. All youth indicated that during orientation, staff	**Exceptions** One of the closed files was missing a staff signature indicating the youth received the shelter handbook. One closed file was missing the form indicating youth had received the handbook.

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						reviewed with youth about the program rules and behavior system. A total of six files (three open, three closed) reviewed. All six files contained an orientation checklist that was completed by staff and the youth within 24 hours of youth's intake date. The handbook signature page was located in all of the open files. One of the closed files was missing a staff signature from this page, and one closed file was missing the form completely.	
3.03: Youth Room Assignment							
Provider has a written policy and procedure that meets the requirement for Indicator 3.03						☒ YES ☐ NO (explain) The agency's policy Section 3-5 Classification meets all the requirement of the QI Indicator. It was last reviewed on August 2014 and approved by the President/CEO.	
RATING	☒	☐	☐	☐	☐	Any program action based on classification is 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 discriminated in the assignment of sleeping arrangements. The program has a board located in the shelter that indicates where each youth	No exceptions are noted for this indicator.

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						sleeps as well as any medications and alerts. There were six files (three open, three closed) reviewed. Each youth file had a completed CINS/FINS intake form signed by staff and supervisor. All youth were assigned an appropriate room.	
3.04: Log Books							
Provider has a written policy and procedure that meets the requirement for Indicator 3.04						☒ YES ☐ NO (explain) The program has a policy and procedures which addresses their process for all logbook requirements. It was reviewed and approved by the President/CEO.	
RATING	☐	☒	☐	☐	☐	A review of a randomly selected sample validated the program captures the following in their logbook entries: safety and security issues, law enforcement contacts, direct care staff review of the logbook for the previous two shifts, the program manager's weekly reviews, supervision, census counts, shift summaries, weather reports, and fifteen minute checks during sleeping hours. The logbook is captured electronically; therefore, there was no evidence of white out being used, and all entries were legible. The electronic version allows for strike-through and examples were verified to be completed as required.	**Exceptions** On-site visitation is not being logged in the logbook. Fourteen of the seventeen CCC calls from the previous six months, were not logged in the logbook. The incidents surrounding the call to the CCC was documented in the logbook.

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						Of the seventeen CCC calls from the previous six months, three were logged in the logbook. Each entry notes the staff and youth name involved, a brief statement of the entry, and name and signature of the staff making the entry.	
3.05: Behavior Management Strategies							
Provider has a written policy and procedure that meets the requirement for Indicator 3.05						☒ YES ☐ NO (explain) The agency has a written policy and procedure that addresses all of the key elements of the QI indicator. The policy was last revised August 2014 and was signed by the President/CEO.	
RATING	☒	☐	☐	☐	☐	The program utilizes the Crosswinds Behavior Model based on the Girls and Boys Town model. This model is to assist in providing training in change behavior techniques to ensure the least restrictive alternative to change behavior. The program has a written description of the behavior management plan that includes positive incentive to encourage participation. The behavior management system is outlined in the Resident's Manual and in intake paperwork. The program uses a Motivation System called the Assessment System that is designed to promote positive youth behavior, accountability, and social	No Exceptions.

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						responsibility. Each youth is placed on the system upon entering the shelter and stays on it for 3 days. While on the Assessment System, the youth use a point card, earning points for appropriate behaviors and losing points for inappropriate behaviors. Youth can exchange points for privileges that can be used the following day. If the youth has more total points lost in one day, he/she does not have privileges for the next 24 hours. If a youth is in the negative total points, the youth forfeits privileges until they receive enough points to get back to zero or above. This is to encourage more positive behaviors. All consequences appear fair in respect to the behavior management plan. Three youth surveys were conducted. Zero of the youth indicated that they have been sent to their room for punishment. Staff and youth were able to verbally explain the Behavior Management System.	
3.06: Staffing and Youth Supervision							
Provider has a written policy and procedure that meets the requirement for Indicator 3.06						☒ YES ☐ NO (explain) The policy and procedures noted in Section 3-19 Staffing and Youth Supervision and Section 3-23 Youth Counts meet all the requirements of the	

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		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						QI Indicator. The Staffing and Youth Supervision policy was revised on August 2019 and approved by the President/CEO. Youth Counts was last revised July 2018 and signed by the President/CEO.	
RATING	☐	☒	☐	☐	☐	The Shelter maintains a staff schedule that ensure that staff to youth ratios will be met on all shifts. During Awake Hours of CINS/FINS Youth the staff to youth ratio is 1 to 6. Awake Hours of Staff Secure Youth the staff to youth ratio is 1 to 5. During Sleep Hours, the staff to youth ratio is 1 to 12. The staff schedule is posted on a bulletin board located in the Staff Room. The names and telephone of on-call staff are listed on top of each schedule. An overtime rotation roster is located on the bulletin board and contains the names and phone numbers of staff. In review of the Staff Schedule binder, the Shelter Manager notes changes red pen, signs, and dates each schedule. This reviewer checked the video against the logbooks for documentation of staff. Three random nights were selected for viewing. All three nights observed showed the staff to youth ratio was in compliance. The bed checks observed on October 20, 2019 were found to be done consistently	**Exceptions** On 9/17/19, Youth Care Worker B. Smith was not in compliance doing bed checks every 15 minutes. Shelter Manager was already aware of the situation due to his random review of bed checks for the that shift. Staff was giving a verbal warning and is no longer scheduled on 3rd shift. On 11/20/19, Youth Care Worker M. Romer indicated a check was done at 12:41, but the video surveillance showed it was completed at 12:47. M. Romer indicated checks were done at 12:23am, 12:50am, 4:30am, 4:46am, 5:09am, 5:17am, 5:30am, and 6:01am. However, video surveillance indicated there was no motion at that time and she did not complete any of those checks. Shelter Manager, COO, and CEO were made aware of the falsification of bed checks. Shelter Manager contacted the CCC within 2 hours of being notified and a report was made. Report #201905252.

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		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						and documented correctly. 1 youth was on sight and sound and the door appeared to be open. There were no discrepancies found. The bed checks observed on September 17, 2019 showed that the staff to youth ratio was in compliance. Youth Care Worker B. Smith was not in compliance doing bed checks every 15 minutes. At 2:01, B. Smith did the bed check and noted in the log book. Bed checks were not completed again until 3:18am. Late entry for the 2:15am check was logged 3:17am did not indicate if youth appeared asleep. Late entry for 2:30am check was logged at 3:18am and did not indicate if you appeared asleep. A late entry for the 2:45am check was completed and logged 3:18am. A late entry for 3:00am check was completed and logged at 3:19am. The next check that was completed was at 3:20am. Shelter Manager found the checks were out of compliance during his review of video and the male staff was given a verbal warning. The Shelter manager also noted to this reviewer that B. Smith is no longer scheduled during 3rd shifts. The bed checks reviewed on November 20, 2019 shows that staff to youth ratio was in compliance. When comparing the video surveillance with the logbook, it was	

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						logged that Youth Care Worker M. Romer did a check at 4:30am, however video indicated that the staff member was in the Staff Room doing trainings at that time. At 4:45, M. Romer indicated a check in the logbook. The video showed that M. Romer was sitting in the Staff Room at this time. The Shelter Manager reviewed the footage from the entire shift. M. Romer indicated in the logbook that she did a check at 12:41am, but the camera footage shows that the check was done at 12:47am. Additionally, M. Romer indicated checks were done at 12:23am, 12:50am, 4:30am, 4:46am, 5:09am, 5:17am, 5:30am, and 6:01am. However, video surveillance indicated there was no motion at that time and she did not complete any of those checks.	
3.07: Video Surveillance System							
Provider has a written policy and procedure that meets the requirement for Indicator 3.07						☒ YES ☐ NO (explain) The agency has a policy and procedure Section 5-14 Video Surveillance System that meets all the requirements of the QI Indicator. The policy was last revised January 2017 and was signed by the President/CEO.	
RATING	☒	☐	☐	☐	☐	Cameras have the ability to record date, time, and location. The cameras maintain resolution that enables facial recognition. The camera is also able to capture motion detection.	No exceptions are noted for this indicator.

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						A written notice of video surveillance is posted by the front doors of the residential facility. The cameras were found in the interior and exterior of the shelter. All cameras were visible, and no cameras were placed in bathrooms of sleeping quarters. The video surveillance can capture and retain video for a minimum of 30 days. The video surveillance has backup in case of power outages. The Shelter Manager or Director of Counseling Services conducts a review of the log book, including random overnight bed checks, once a week and indicates they have reviewed the log book. A list was provided that indicates the COO, CFO, Director of Counseling, and Shelter Manager has access to the CCTV as of November 21, 2019. The COO handles third-party requests to view video.	

STANDARD 4: MENTAL HEALTH/HEALTH SERVICES

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
Standard Four – Mental Health /Health Services							
4.01: Healthcare Admission Screening							
Provider has a written policy and procedure that meets the requirement for Indicator 4.01						☒ **YES** ☐ **NO (explain)** The program has a policy and procedure that focuses on addressing the function of providing Healthcare Admission Screening. The agency's policy and procedure were reviewed onsite by this reviewer. The agency's policy does adhere to the general requirements of this indicator. The agency's policy is signed by the program's CEO.	
RATING	☒	☐	☐	☐	☐	The reviewer made a request for the agency to provide all current active client case files roster for the last 6 months. The reviewer also selected a sample two (2) closed client files to review. The agency uses the Client Emergency/Admission Information form and the CINS/FINS Intake form to screen for past and current health and medical issues. A total of six (6) client case files were reviewed onsite to assess the agency's ability to effectively screen and accurately document past and current acute health issues as part of the admission process.	**Exceptions** A review of six (6) client files found that 1 of the 6 client files documented that the client was on four (4) medications on the Client Emergency/Admission Information form. The reviewer found that only a total three(3) medications were listed on page two(2) of the CINS/FINS Intake form.
4.02 Suicide Prevention							

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
There is a written plan that details the program's suicide prevention and response procedures. The plan complies with the procedures outlined in the Florida Network's Policy and Procedure Manual for CINS/FINS.							
Provider has a written policy and procedure that meets the requirement for Indicator 4.02						☒ **YES** ☐ **NO (explain)** The program has a Suicide Prevention policy. The Suicide Prevention policy does include procedures that are inclusive of major steps of supervision of youth placed in residential. The program has policy and procedures which addresses their process for supervising and addressing all of the agency's youth placed on elevated supervision. The policy was reviewed and signed by the program's CEO.	
RATING	☒	☐	☐	☐	☐	The agency requires that all eligible youth admitted to the agency be screened for past and or current risks related to determining the degree of possibilities or self-harming behavior. The agency requires that each youth be screened using the six (6) questions from the Florida network's intake assessment form. Each youth is required to be asked the 6 questions and utilize this form to determine past or present existence of suicide risk. This form documents the youth's responses to those 6 questions. In the event that the youth answers yes to any of those suicide risk questions, they are required to be placed on elevated supervision until a full assessment is completed and or reviewed approved by a clinician.	No exceptions are noted for this indicator.

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		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						The agency had a total of 4 samples of suicide risk to review. Review of these client case files that have been placed on elevated supervision indicated that each file contained a documented suicide risk screening that occurred during the initial intake screening process. All four (4) client files contain a suicide screening with results that had been reviewed and signed by the designated supervisor and or clinician overseeing this process. There is evidence that each youth was placed on sight and sound supervision until the assessment was reviewed by a licensed clinician. Each youth was assessed during the admission process found the youth was placed on the property at supervision level. Staff persons in the youth shelter monitored and documented the youth's behavior and status every 30 minutes or less. There is documented evidence that the supervision level was not changed or reduced until the licensed clinician gave approval to do so. The licensed clinician's credentials are documented on the assessment form and the times that the youth was observed by staff in the shelter are also documented. The times are documented from the time that they started sight and sound supervision, to the time that the youth was taken off elevated supervision. There evidence in the agency's NoteActive logbook to verify that the youth were placed on and stepped	

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		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						down from elevated supervision. There is verification that the agency conducted youth status checks every thirty minutes or less.	
4.03: Medication							
Provider has a written policy and procedure that meets the requirement for Indicator 4.03						☒ **YES** ☐ **NO (explain)** The agency has a medication policy. The medication policy contains a policy number and detailed information about the agencies approach to providing assisting in the delivery of medication to eligible residents during their shelter stay. The policy meets the general requirements for the indicator and is signed and approved by the agency's CEO.	
RATING	☐	☒	☐	☐	☐	The policy requires that agency staff members follow a medication distribution protocol. The agency requires a staff member to verify that the medication is assigned properly to the resident that is listed as receiving the medication. The agency does this by verifying the medication(s) with the local pharmacy as listed on the resident's medication. The agency does document that the medication is stored in a secure location. The agency then creates a medication distribution document to log and account for all medication distributed and counted doing the residence shelter stay.	**Exceptions** The agency did not produce evidence that consistent and ongoing monthly reviews of medication management practice using the Pyxis at station 4000 portal to produce reports is a regular monthly practice to assess medication distribution practice. The agency primarily produces an auto generated inventory report. The agency's medication distribution training is primarily delivered by the shelter manager and lead youth care staff person and not the Registered Nurse.

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		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						The agency stores all medications in a Pyxis MedStation 4000 cabinet. The cabinet is secured in the shelter behind a locking door in the youth care and clinician station. The agency has evidence of a total of the minimum two super users and several general users for the MedStation. The agency verifies medication using 1of 4 methods. The agency does not except residents with injectable medications unless the youth are prescribed an EpiPen. The agency stores all medications separate from injectable and topical medications in the MedStation. The agency does require that the nurse training all staff on general medication distribution and use of EpiPen's when the Registered Nurse is on duty. The agency has a small refrigerator dedicated to medications that require call Storage. This refrigerator maintains the temperature requirements for cold medication storage. All narcotic and controlled medications are stored in the med stations and counted on each shift. The agency also maintains a perpetual inventory with a running balance is for all controlled substances. Only trained staff and specific users have permission to access the MedStation. All sharps and syringes are secured as required and counted on a Weekly basis. Our medications are distributed by the Registered Nurse when they are on duty. Discrepancies rarely occur, and it is the	

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		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						agency's practice to clear them at the end of each shift.	
4.04: Medical/Mental Health Alert Process							
Provider has a written policy and procedure that meets the requirement for Indicator 4.04						☒ **YES** ☐ **NO (explain)** The agency has a detailed written policy related to providing and executing their medical and mental health in the process. The policy includes the policy number and timeframe that it was reviewed. The policy includes the most up-to-date revisions and has been approved by the agencies CEO. A general review of the policy indicates that the policy meets the general requirements for this indicator.	
RATING	☒	☐	☐	☐	☐	The agency policy requires that all staff members be trained to screen and document current conditions all eligible youth admitted to the program. The agency requires that each staff be trained to ask questions on past and existing allergies and or medical or mental health conditions. Review of the existing active client files and two (2) additional closed files indicate that each admission to the program be properly screened using the program's alert system. If a client responds positive for an allergy staff are provided information instructions to recognize and respond to the need for medical care for the resulting medical or mental health	No exceptions are noted for this indicator.

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						problem. The agency has a medical and mental health alert system in place that uses the color-coding notification process. The current color-coding alert system indicates yellow for suicide, red for medication and mental health issues, green for allergies, blue for continuous sight and sound, orange for mental health, purple for physical aggression and black for staff secure status youth. A review of current active files indicates that the agency is screening for the aforementioned alerts and documenting any and all food allergies, mental health and or medical conditions associated with each individual client admitted to the youth shelter.	
4.05: Episodic/Emergency Care							
Provider has a written policy and procedure that meets the requirement for Indicator 4.05						☒ **YES** ☐ **NO (explain)** The agency has a written policy on episodic of an emergency care. The policy includes a policy number, the date of the last review, all revisions and verification that the policy has been approved by the agency's CEO. The general review of the policy indicates that it meets all the requirements to address the components of this indicator.	

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
RATING	☒	☐	☐	☐	☐	The agency has an episodic emergency response system that all staff are required to execute. The episodic and emergency care response system requires all staff to be able to identify and respond to various types of medical emergencies that could occur on site. The policy requires staff to identify emergency issues, respond to them with the minimum required care, notify management and the parent/guardian, and if necessary transport youth to a medical facility or call for onsite emergency care assistance. Review of the current client files on site indicates that none of the clients required emergency care during the shelter stay. A review of the agency's episodic and emergency care log indicated that were no incidents for the current month. In addition, a review of the log indicates that there are total of nine (9) medications/dental care incidents documented since mid-May 2019. There are incidents documented that required medical or dental care. Upon return from receiving medical care, the agency verified receipt of a medical clearance and has documented evidence of discharge instructions with necessary follow-up. All incidents indicate that the parent has been contacted as required. There is evidence that staff are trained on emergency procedures. The agency does have	No exceptions are noted for this indicator.

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						emergency medical equipment that includes a knife for life, defibrillators and first aid kit and supplies.	