County of Los Angeles
DEPARTMENT OF CHILDREN AND FAMILY SERVICES

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September 3, 2010

To: Supervisor Gloria Molina, Chair
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From: Patricia S. Ploehn, LCSW
Director

LEROY HAYNES CENTER CONTRACT COMPLIANCE MONITORING REVIEW

In accordance with your Board's April 14, 2009 motion, we are informing your Board of the results of a group home compliance review.

Leroy Haynes Center is located in the 5th Supervisorial District, Los Angeles County, and provides services to Los Angeles County Department of Children and Family Services' (DCFS) foster youth. According to Leroy Haynes Center's program statement, its stated goal is "to provide intense counseling, milieu treatment and daily care to abused and troubled children who have emotional and/or behavioral problems," and the agency is licensed to serve a capacity of 72 children, ages 7 through 18.

The Out-of-Home Care Management Division (OHCMD) conducted a review of Leroy Haynes Center in January 2010, at which time it had one 72-bed site with 29 DCFS placed children. All 29 children were males. For the purpose of this review, 15 placed children's case files were reviewed, and 14 children were interviewed as one child was discharged from Leroy Haynes Center before the OHCMD Monitor was able to interview the child. The children's overall average length of placement was six months, and the average age was 15. Fifteen staff files were reviewed for compliance with Title 22 regulations and contract requirements.

Ten children were on psychotropic medication, and we reviewed their case files to assess timeliness of psychotropic medication authorizations and confirm that medication logs documented that correct dosages were administered as prescribed.

SCOPE OF REVIEW

The purpose of this review was to assess Leroy Haynes Center's compliance with the contract and State regulations. The visit included a review of Leroy Haynes Center's program statement, administrative internal policies and procedures, 15 children's case files, and a random sampling of personnel files. A visit was made to the site to assess the quality of care and supervision provided to children, and we conducted interviews with children to assess the care and services they were receiving.

A copy of this report has been sent to the Auditor-Controller (A-C) and Community Care Licensing (CCL).

SUMMARY

Generally, Leroy Haynes Center was providing good quality care to DCFS placed children, and the services were provided as outlined in its program statement. The children's case files and personnel files were well organized and professionally maintained. The site was clean and adequately landscaped. All 14 children interviewed disclosed that they felt safe at the Group Home.

At the time of the review, the Group Home needed to address a few minor physical plant deficiencies, develop comprehensive Needs and Services Plans (NSP) and ensure that children's initial dental exams were timely.

The Executive Director and his management staff were accessible, cooperative, motivated and committed to making the necessary corrections to findings highlighted during the review.

NOTABLE FINDINGS

The following are the notable findings of our review:

- While current psychotropic medication authorizations were on file for all ten children on psychotropic medication, evaluations were conducted, and medication logs were properly maintained, one of the ten children said that he was not informed about his psychotropic medication. The OHCMD Monitor immediately discussed this with the Program Director who stated that the consultant Psychiatrist informs the children about the psychotropic medication and that the children usually sign that they were informed about the psychotropic medication and the side effects on the Informed Consent for the Administration of Psychotropic Medication form, however no signed Informed Consent form was found for this child during the review.

- Thirteen of the 15 children whose files were reviewed had timely initial dental exams. However, the initial dental exam was 50 days late for one child who had been placed for 80 days and 38 days late for another child who had been placed for 68 days at Leroy Haynes Center.

- Of the 15 case files reviewed, all 15 initial NSPs were comprehensive, and of the 22 updated NSPs reviewed, 13 were comprehensive and met all the required elements in accordance with the NSP template. Nine updated NSPs were not comprehensive, as one needed to have more detailed information on visits a child was having with his family and eight needed more detail on the Group Home contacts with DCFS CSWs.

- While we noted sufficient food during our review and 13 of 14 children interviewed stated that the food was satisfactory, one child reported that he was not satisfied with the food.

- One staff member's CPR certificate had expired. This was brought to the attention of the Quality Assurance Coordinator during the site visit, and she immediately scheduled CPR training for the staff.

The detailed report of our findings is attached.

EXIT CONFERENCE

The following are highlights from the exit conference held March 24, 2010:

In attendance:

Daniel Maydeck, Executive Director, Frank Linebaugh, Assistant Executive Director, Derrick Perry, Program Director, Joy Gahring, Quality Assurance Coordinator, William Harris, Unit Manager, Shannine Crockett, Unit Manager, Reggie Varner, Unit Manager, Sharon Elzy, Unit Manager, Mechelle Siles, Unit Manager, and Glen Robinson, Unit Manager, Leroy Haynes Center; and Kirk Barrow, Monitor, DCFS OHCMD.

Highlights:

The Executive Director reported that Leroy Haynes Center had made great effort to improve the development of NSPs and that he would make sure that continued. He also noted that Leroy Haynes Center made major facility renovations prior to the review and that the deficiencies regarding the facility noted during the review had already been corrected.

The Quality Assurance Coordinator reported that, shortly after the review, the staff member whose CPR certificate had expired had completed the CPR recertification training, and her CPR certificate was expected soon and would be placed in her personnel file. She concurred that two boys' initial dental exams were late and the Director of Residential Care stated that he would make sure that children receive timely initial dental exams.

As agreed, Leroy Haynes Center provided a timely written Corrective Action Plan (CAP) addressing each recommendation noted in this compliance report. The CAP is attached.

As noted in the monitoring protocol, a follow up visit will be conducted to address the provider's approved CAP and assess for full implementation of recommendations.

If you have further questions, please call me or your staff may contact Armand Montiel, Board Relations Manager, at (213) 351-5530.

PSP:LP:MG
EAH:DC:kb

Attachments

c: William T Fujioka, Chief Executive Officer
Wendy Watanabe, Auditor-Controller
Donald H. Blevins, Chief Probation Officer
Public Information Office
Audit Committee
Sybil Brand Commission
Philip Talleur, President, Board of Directors, Leroy Haynes Center
Daniel Maydeck, Executive Director, Leroy Haynes Center
Jean Chen, Regional Manager, Community Care Licensing
Lenora Copeland, Regional Manager, Community Care Licensing

LEROY HAYNES CENTER PROGRAM CONTRACT COMPLIANCE MONITORING REVIEW

Leroy Haynes Center
233 Baseline Avenue
La Verne, California 91750
License Number 191501972
Rate Classification Level 12

The following report is based on a "point in time" monitoring visit and addresses findings noted during the January 2010 monitoring review.

CONTRACTUAL COMPLIANCE

Based on our review of 15 children's files and 15 staff files, and documentation from the provider, Leroy Haynes Center was in full compliance with three of nine sections of our Contract Compliance review: Licensure/Contract Requirements; Education and Emancipation Services; and Recreation and Activities. The following report details the results of our review.

LICENSURE/CONTRACT REQUIREMENTS

Based on our review of 15 children's case files and/or documentation from the provider, Leroy Haynes Center fully complied with all nine elements reviewed in the area of Licensure/Contract Requirements.

Recommendation:

None

FACILITY AND ENVIRONMENT

Based on our review of Leroy Haynes Center Group Home, review of 15 children case files and documentation from the provider, Leroy Haynes Center fully complied with four of six elements in the area of Facility and Environment.

Generally, the exterior of the Group Home was well maintained. The front and back yards were clean and adequately landscaped. The Group Home maintained age-appropriate and accessible recreational equipment in good condition and age appropriate for placed youths. The Group Home had an appropriate quantity and quality of reading materials, and educational resources and supplies, including computers readily available to children. The Group Home maintained a sufficient supply of perishable and non-perishable foods. A shower curtain was missing from the downstairs bathroom in Thurbar cottage, and Christmas lights with electrical wiring were used as decoration in one child's bedroom in Burton cottage. The wiring was not connected to an electrical outlet and did not present a safety hazard at the time. However, the monitor requested that the electrical wiring be removed prior to the monitor exiting the cottage at the time of the inspection. At the Exit Conference, the Executive Director made the monitor aware that the shower curtain was replaced immediately after the facility inspection. Prior to the conclusion of the Exit Conference, the monitor inspected the cottage to verify that the shower curtain was up in the bathroom and that there was no electrical wiring in any room.

The Auditor-Controller's (A-C) prior report dated April 8, 2009 also noted that Leroy Haynes Group Home did not always ensure that the Group Home's facility was maintained in accordance with CDSS Title 22 regulations.

Recommendations:

Leroy Haynes Center Management shall ensure that:

1. All bathrooms have shower curtains.

2. Electrical wiring is not hanging in children's bedrooms.

PROGRAM SERVICES

Based on our review of 15 children's case files and documentation from the provider, Leroy Haynes Center fully complied with six of eight elements reviewed in the area of Program Services.

We noted that the placed children met the Group Home's population criteria as outlined in the program statement, and they were receiving required therapeutic services.

Based on our review, we found that the Group Home obtained the DCFS CSWs' authorization to implement the Needs and Services Plan (NSP) and the treatment team developed and implemented the NSPs with the participation of age-appropriate children and discussed them with the Group Home staff. All fifteen initial NSPs reviewed were comprehensive, and of the 22 updated NSPs reviewed, 13 were comprehensive and met all the required elements in accordance with the NSP template. Nine updated NSPs were not comprehensive; eight needed to have more detailed information on the Group Home monthly contacts with the DCFS CSWs, and one had no detailed information on the visits a child was having with his relative.

The A-C's prior report dated April 8, 2009 also noted that Leroy Haynes Center did not always ensure that NSPs were comprehensive.

Recommendations:

Leroy Haynes Center Management shall ensure that:

3. Staff develop comprehensive NSPs that have sufficient details on the visits the children have with their relatives and that staff document detailed information on the Group Home contacts with DCFS CSWs.

EDUCATIONAL AND EMANCIPATION SERVICES

Based on our review of 15 children's case files and documentation from the provider, Leroy Haynes Center fully complied with all four elements reviewed in the area of Educational and Emancipation Services.

Recommendation:

None

RECREATION AND ACTIVITIES

Based on our review of 15 children's case files and documentation from the provider, Leroy Haynes Center fully complied with all three elements reviewed in the area of Recreation and Activities.

Recommendation:

None

CHILDREN'S HEALTH-RELATED SERVICES, INCLUDING PSYCHOTROPIC MEDICATION

Based on our review of 15 children's case files and documentation from the provider, Leroy Haynes Center fully complied with eight of nine elements in the area of Children's Health-Related Services, including Psychotropic Medication.

The Group Home maintained current court-approved authorizations for the ten children taking psychotropic medication, there were current psychiatric evaluations/reviews for each child on psychotropic medication, and medication logs were properly maintained. Initial medical exams and follow-up medical/dental exams were timely.

Thirteen of the 15 children's files reviewed showed that the initial dental exams were timely. However, the initial dental exam was 50 days late for one child who was placed for 80 days and 38 days late for another child who was placed for 68 days at Leroy Haynes Center.

Recommendations:

Leroy Haynes Center Management shall ensure that:

4. Children's initial dental examinations are timely and/or maintain documentation as to why exams were not timely.

PERSONAL RIGHTS

Based on our review of 15 children case files and documentation from the provider, Leroy Haynes Center fully complied with nine of 11 elements in the area of Personal Rights.

All interviewed children reported that they were informed of the Group Home's policies and procedures, that they were treated with respect and dignity and that an appropriate rewards and discipline system was in place. They were allowed to make and receive personal telephone calls, send and receive unopened mail and have private visits. The children reported that they attended the religious services of their choice and that chores were reasonable, and they had rights to receive or voluntarily reject medical, dental and psychiatric care.

While we noted sufficient food during our review and 13 of the 14 interviewed children stated that the food was satisfactory, one child reported dissatisfaction with the meals and snacks. One child reported that he was not told the reasons for his psychotropic medication.

During the Exit Conference, the Executive Director stated that the Group Home made all efforts to ensure that the children receive nutritious quality food but that does not mean that all the children will enjoy the food. The Program Director stated that the consultant Psychiatrist informs the children about the psychotropic medication and that the children usually sign that they were informed about the psychotropic medication and the side effects on the Informed Consent for the Administration of Psychotropic Medication form, however no Informed Consent form was found signed for one child during the review and he disclosed during the interview that he was not told the purpose of his psychotropic medication.

Recommendation:

Leroy Haynes Center Management shall ensure that:

5. Input of menu items and food surveys are obtained from children in an effort to ensure their satisfaction with the food.

6. All children are told what their psychotropic medication is for and that their signature is documented on the Informed Consent form.

CLOTHING AND ALLOWANCE

Based on our review of 15 children's case files and documentation from the provider, Leroy Haynes Center fully complied with seven of eight elements reviewed in the area of Clothing and Allowance.

All 14 children interviewed said that they received at least $50 per month clothing allowance. They had an adequate quantity and quality of clothing and were involved in the selection of their wardrobe. They had adequate personal care items which were readily accessible. All 14 children said they were provided with at least the minimum monetary allowances and they were free to manage their allowances. Twelve of the 14 children interviewed said they were encouraged and assisted in creating and updating a lifebook/photo album, however two said that they did not have a lifebook. During the Exit Conference, the Quality Assurance Coordinator stated that Leroy Haynes is committed to assuring that all children have lifebooks/photo albums, but admitted that the two children did not have lifebook/photo albums at the time of the review. The two children were given lifebooks shortly after the review.

Recommendation:

Leroy Haynes Center Management shall ensure that:

7. All children are encouraged and assisted in creating and updating a lifebook/photo album.

PERSONNEL RECORDS

Based on our review of 15 staff personnel files and documentation from the provider, Leroy Haynes Center fully complied with 11 of 12 elements reviewed in the area of Personnel Records.

All 15 staff reviewed met the educational/experience requirements, submitted timely criminal fingerprint cards, had Child Abuse Index (CAI) clearances on file, and signed a criminal background statement in a timely manner. They also received timely health-screenings, had valid driver's licenses, completed First Aid, and signed copies of the Group Home policies and procedures. Fifteen staff members who were required to have initial and on-going training received the required training.

Fourteen of 15 staff members received CPR training; however one staff member did not have a current CPR certification.

Recommendation:

Leroy Haynes Center Management shall ensure that:

8. All staff members who work directly with the children receive current CPR training and have current CPR certification on file.

PRIOR YEAR FOLLOW-UP FROM THE AUDITOR-CONTROLLER'S REPORT

Objective

Determine the status of the recommendations reported in the A-C's prior monitoring review.

Verification

We verified whether the outstanding recommendations from the A-C's report issued April 8, 2009 were implemented.

Results

The A-C's prior monitoring report contained four outstanding recommendations. Specifically, Leroy Haynes Center was to improve the upkeep of the Group Home, develop comprehensive NSPs and include all members of the treatment team in the development and implementation of NSPs, obtain current court authorizations for all children taking psychotropic medication, and encourage and assist children in creating and maintaining photo albums/lifebooks. Based on our follow up of these recommendations, Leroy Haynes Center fully implemented one of the A-C's recommendations as it relates to obtaining current court authorizations for children taking psychotropic medication. However, Leroy Haynes Center did not fully implement the A-C's recommendations regarding facility upkeep, comprehensive NSPs, and assisting children in creating and maintaining photo albums/lifebooks. As noted, the recommendations were partially implemented.

In response to the draft report, Leroy Haynes Center indicated that the agency was in substantial compliance with CDSS Title 22 regulations related to Facility and Environment and in correcting deficiencies noted in the A-C's report dated April 8, 2009. The A-C's Report in April 2009 noted 13 Facility and Environment deficiencies, none of which were noted during 2010 Compliance Monitoring Review Report. The agency made significant physical plant improvements in 2009 at substantial cost to the agency. These physical plant improvements included new bedroom furniture for every child's bedroom and new paint, flooring and window coverings throughout the living units. Despite these improvements, corrective action was requested of Leroy Haynes Center to further address the A-C's findings.

Recommendation:

Leroy Haynes Center management shall ensure that:

9. It fully implements the three outstanding recommendations from the A-C's monitoring report dated April 8, 2009, which are noted in this report as Recommendations 1, 3 and 7.

LEROY HAYNES CENTER GROUP HOME
CONTRACT COMPLIANCE MONITORING REVIEW-SUMMARY
233 Baseline Avenue
La Verne, CA 91750
License Number: 191501972
Rate Classification Level: 12

	Contract Compliance Monitoring Review	Findings: January 2010
I	**Licensure/Contract Requirements** (9 Elements) 1. Timely Notification for Child's Relocation 2. Stabilization to Prevent Removal of Child 3. Transportation 4. SIRs 5. Compliance with Licensed Capacity 6. Disaster Drills Conducted 7. Disaster Drill Logs Maintenance 8. Runaway Procedures 9. Allowance Logs	Full Compliance (ALL)
II	**Facility and Environment** (6 Elements) 1. Exterior Well Maintained 2. Common Areas Maintained 3. Children's Bedrooms/Interior Maintained 4. Sufficient Recreational Equipment 5. Sufficient Educational Resources 6. Adequate Perishable and Non Perishable Food	1. Full Compliance 2. Improvement Needed 3. Improvement Needed 4. Full Compliance 5. Full Compliance 6. Full Compliance
III	**Program Services** (8 Elements) 1. Child Population Consistent with Program Statement 2. DCFS CSW Authorization to Implement NSPs 3. Children's Participation in the Development of NSPs 4. NSPs Implemented and Discussed with Staff 5. Therapeutic Services Received 6. Recommended Assessments/Evaluations Implemented 7. DCFS CSWs Monthly Contacts Documented 8. Comprehensive NSPs	1. Full Compliance 2. Full Compliance 3. Full Compliance 4. Full Compliance 5. Full Compliance 6. Full Compliance 7. Improvement Needed 8. Improvement Needed
IV	**Educational and Emancipation Services** (4 Elements) 1. Emancipation/Vocational Programs Provided 2. ILP Emancipation Planning 3. Current IEPs Maintained 4. Current Report Cards Maintained	Full Compliance (ALL)

V	**Recreation and Activities** (3 Elements) 1. Participation in Recreational Activity Planning 2. Participation in Recreational Activities 3. Participation in Extra-Curricular, Enrichment and Social Activities	Full Compliance (ALL)
VI	**Children's Health-Related Services (including Psychotropic Medications)** (9 Elements) 1. Current Court Authorization for Administration of Psychotropic Medication 2. Current Psychiatric Evaluation Review 3. Medication Logs 4. Initial Medical Exams Conducted 5. Initial Medical Exams Timely 6. Follow-up Medical Exams Timely 7. Initial Dental Exams 8. Initial Dental Exams Timely 9. Follow-Up Dental Exams Timely	1. Full Compliance 2. Full Compliance 3. Full Compliance 4. Full Compliance 5. Full Compliance 6. Full Compliance 7. Full Compliance 8. Improvement Needed 9. Full Compliance
VII	**Personal Rights** (11 Elements) 1. Children Informed of Home's Policies and Procedures 2. Children Feel Safe 3. Satisfaction with Meals and Snacks 4. Staff Treatment of Children with Respect and Dignity 5. Appropriate Rewards and Discipline System 6. Children Free to Receive or Reject Voluntary Medical, Dental and Psychiatric Care 7. Children Allowed Private Visits, Calls and Correspondence 8. Children Free to Attend Religious Services/Activities 9. Reasonable Chores 10. Children Informed about Psychotropic Medication 11. Children Aware of Right to Refuse Psychotropic Medication	1. Full Compliance 2. Full Compliance 3. Improvement Needed 4. Full Compliance 5. Full Compliance 6. Full Compliance 7. Full Compliance 8. Full Compliance 9. Full Compliance 10. Improvement Needed 11. Full Compliance
VIII	**Children's Clothing and Allowance** (8 Elements) 1. $50 Clothing Allowance 2. Adequate Quantity of Clothing Inventory 3. Adequate Quality of Clothing Inventory 4. Involvement in Selection of Clothing 5. Provision of Personal Care Items 6. Minimum Monetary Allowances	1. Full Compliance 2. Full Compliance 3. Full Compliance 4. Full Compliance 5. Full Compliance 6. Full Compliance

	7. Management of Allowance 8. Encouragement and Assistance with Life Book	7. Full Compliance 8. Improvement Needed
IX	**Personnel Records (including Staff Qualifications, Staffing Ratios, Criminal Clearances and Training)** (12 Elements) 1. Education/Experience Requirement 2. Criminal Fingerprint Cards Timely Submitted 3. CAIs Timely Submitted 4. Signed Criminal Background Statement Timely 5. Employee Health Screening Timely 6. Valid Driver's License 7. Signed Copies of GH Policies and Procedures 8. Initial Training Documentation 9. CPR Training Documentation 10. First Aid Training Documentation 11. On-going Training Documentation 12. Emergency Intervention Training Documentation	1. Full Compliance 2. Full Compliance 3. Full Compliance 4. Full Compliance 5. Full Compliance 6. Full Compliance 7. Full Compliance 8. Full Compliance 9. Improvement Needed 10. Full Compliance 11. Full Compliance 12. Full Compliance

LEROY HAYNES
STRENGTHENING MIND & SPIRIT
PROGRAMS FOR THE DEVELOPMENT OF CHILDREN
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(909) 593-2581 • Fax: (909) 596-3567 • Tax I.D.# 95-1506150

July 26, 2010

Dorothy Channel
LA DCFS
Out of Home Care Management Division
9320 Telestar Ave.
El Monte, CA 91731

Dear Ms. Channel,

On behalf of Leroy Haynes Center, I would like to thank you for the Contract Compliance Review Results received on April 24, 2010.

We appreciate the feedback and want to work cooperatively with the Department to improve the quality of our services.

Attached is the Corrective Action Plan as requested.

Please contact me if you have any questions.

Sincerely,

Joy Gahring
QA Coordinator

Leroy Haynes Center
Corrective Action Plan
DCFS Out Of Home Care Management
Group Home Contract Compliance Review
July 26, 2010

The Agency appreciates the collaborative relationship that has developed with the DCFS Out of Home Care Management Division and continues to welcome the feedback provided as part of the Group Home Contract Compliance Review.

The following Corrective Action Plans (CAP's) requested on Group Home Contract Compliance Review Field Exit Summary dated April 7, 2010 for the Group Home Evaluation that took place in January 2010 have been developed and implemented.

I. Licensure/Contract Requirements

There were no issues noted.

II. Facility and Environment

Finding

Shower curtain missing from downstairs bathroom in Thurber Cottage

Corrective Action Plan

The shower curtain was replaced in January 2010. The Unit Manager will ensure that all missing or damaged shower curtains are replaced immediately

This plan has been implemented.

Person Responsible for implementation: Derrick Perry, Program Director

Finding

Electrical/Christmas wiring connected to electrical outlet in Room 2 in Burton Cottage

Corrective Action Plan

The wiring was removed immediately. The Unit Manager will ensure that residents do not hang electrical wiring/Christmas lights in any bedroom.

This plan has been implemented.

Person Responsible for implementation: Derrick Perry, Program Director

III. Program Services

Finding

One resident's NSP dated 1/14/10 has no Group Home contact with his CSW documented

Corrective Action Plan

The Child Advocate of the resident in question was in regular contact with his CSW but failed to include the documentation regarding this contact on the NSP. The Unit Managers were instructed by the QA Coordinator to ensure that the following documentation regarding visitation details is included in all Needs and Services Plans:

a) Dates and details of all Group Home Staff and child contact with CSW's
b) Dates and details regarding all contact by child with family and significant others

This plan has been implemented.

Person Responsible for implementation: Derrick Perry, Program Director

IV. Educational and Emancipation Services

There were no issues noted.

V. Recreation and Activities

There were no issues noted.

VI. Children's Health Related Services, including Psychotropic Medication

Finding

Two residents did not have initial dental examinations performed in a timely manner.

Corrective Action Plan

The Health Services Clerk failed to schedule the initial dental exams in a timely manner. This is a performance issue and the Health Services Clerk was counseled about the importance of insuring these exams are scheduled in a timely manner. The agency nurse will audit the files of all new residents to ensure that all required medical and dental exams are scheduled in a timely manner.

This plan has been implemented.

Person Responsible for implementation: Derrick Perry, Program Director

VII. Personal Rights

Finding

One child reported that he was not satisfied with meals and snacks.

Corrective Action Plan

The Agency will continue current practice of requesting regular input from all residents regarding meals and snacks. In addition, all residents are encouraged to report concerns with meals and snacks to the members of the Resident Council; each living unit has 1 resident representative on the Resident Council which meets weekly.

This plan has been implemented.

Person Responsible for implementation: Derrick Perry, Program Director

Finding

One child reported that he was not informed about his psychotropic medication

Corrective Action Plan

The Consultant Psychiatrist will complete the Informed Consent for the Administration of Psychotropic Medication each time he prescribes a new psychotropic medication. This documentation will reflect that he has informed the child about the effects and benefits of the medication prior to the child starting the medication. In addition, the Agency nurse will meet with each child when a new psychotropic medication is ordered and regarding the effects and benefits of the medication. The Agency nurse will document all contacts with children on a Medication Support Note which is maintained in the Mental Health file of all children on psychotropic medication.

The Agency nurse will ensure that the Consultant Psychiatrist completes an Informed Consent for the Administration of Psychotropic Medication each time he prescribes a new psychotropic medication. The Agency Nurse will ensure that new psychotropic medications are not administered until the Informed Consent for the Administration of Psychotropic Medication has been completed by the Consultant Psychiatrist.

The Agency Nurse met with Deon. C on June 16, 2010 regarding his psychotropic medication. She reviewed effects and benefits of the medication with him at that time and recorded her contact on a Medication Support Note.

This plan has been implemented.

Person Responsible for implementation: Tisha Langley, Director of Mental Health Services and Derrick Perry, Residential Director

VIII. Clothing and Allowance

Finding

Two residents reported they did not have a life book.

Corrective Action Plan

The Unit Manager of each resident will ensure that the resident is provided with the opportunity and materials to create and maintain a life book if he chooses.

This plan has been implemented.

Persons Responsible for implementation: Derrick Perry, Program Director

IX. Personnel Records

Finding

The CPR Certificate of one employee had expired.

Corrective Action Plan

The Agency Training Coordinator and Human Resources Department staff will work collaboratively to ensure that all staff receives CPR training prior to the expiration of their CPR Certificate.

This plan has been implemented.

Person Responsible for implementation: Frank Linebaugh Sr. Vice-President

Respectfully Submitted,

Derrick Perry
Program Director