County of Los Angeles
DEPARTMENT OF CHILDREN AND FAMILY SERVICES

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January 29, 2014

To: Supervisor Don Knabe, Chairman
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Supervisor Zev Yaroslavsky
Supervisor Michael D. Antonovich

From: Philip L. Browning
Director

ST. ANNE'S MATERNITY GROUP HOME CONTRACT COMPLIANCE MONITORING REVIEW

The Department of Children and Family Services (DCFS) Out-of-Home Care Management Division (OHCMD) conducted a review of St. Anne's Maternity Group Home (the Group Home) in October 2013. The Group Home has one site located in the First Supervisorial District and provides services to DCFS foster children, as well as Los Angeles County Probation Department youth. According to the Group Home's program statement, its purpose is "to provide services to at risk and pregnant or parenting young mothers and their children up to 3 years of age."

The Group Home has a 32-bed site and is licensed to serve a capacity of 32 girls, ages 11 through 19. At the time of review, the Group Home served 26 placed DCFS children and 1 Probation youth. The placed children's overall average length of placement was 7 months, and their average age was 17.

SUMMARY

During OHCMD's review, the interviewed children generally reported: feeling safe at the Group Home; having been provided with good care and appropriate services; being comfortable in their environment and treated with respect and dignity.

The Group Home was in full compliance with 6 of 10 areas of our Contract compliance review: Facility and Environment; Education and Workforce Readiness; Health and Medical Needs; Psychotropic Medication; Personal Needs/Survival and Economic Well-Being; and Discharged Children.

OHCMD noted deficiencies in the areas of Licensure/Contract Requirements, related to a facility vehicle in which, children are transported was not maintained in good condition, Special Incident Reports were not appropriately documented or cross-reported timely, and Community Care Licensing (CCL) cited the Group Home, as a result of deficiencies and findings noted during investigations; Maintenance of Required Documentation and Service Delivery, related to DCFS Children's Social Worker's (CSW) or the Deputy Probation Officer's (DPO) authorization to implement NSPs was not obtained; the Group Home did not properly document monthly contacts with the DCFS CSWs or DPO; and NSPs were not comprehensive, as they did not include all of the elements in accordance with the

NSP template; Personal Rights and Social/Emotional Well-Being, related to some children reporting that they were not provided with sufficient amount of food during meals; and Personnel Records, related to one staff member not having completed timely health screenings.

Attached are the details of our review.

REVIEW OF REPORT

On October 31, 2013, the DCFS OHCMD Monitor, Jui Ling Ho, held an Exit Conference with the Group Home representative, Dana Anthony "Tony" Walker, President and Chief Executive Officer; Carlos Tobar, Quality Assurance Director; Lauri Collier, Senior Director; Maryam Sesay, Residential Services Director; Erin Porter, Residential Assistant Director; Rachael Benage, Residential Assistant Director; Bethaby Walczak, Residential Assistant Director; Reza Khosrowabadi, Quality Assurance Specialist; Sharon Spira-Cushnir, Chief Operating Officer; and Lisa Zavala, Lead Program Assistant. The Group Home representatives: were in agreement with the review findings and recommendations; were receptive to implementing systemic changes to improve compliance with regulatory standards; and to address the noted deficiencies in a Corrective Action Plan (CAP).

A copy of this compliance report has been sent to the Auditor-Controller and Community Care Licensing.

The Group Home provided the attached approved CAP addressing the recommendations noted in this compliance report. OHCMD will confirm that these recommendations have been implemented during our next visit to the Group Home in March 2014 to provide the Group Home with technical assistance and follow-up to ensure implementation of the recommendations.

Additionally, with the upcoming implementation of the Contract Monitoring Section, we will be able to focus more on quality assurance for an increased uniform standard and comprehensive measure of overall programmatic efficacy by providing additional training, support, and oversight to the GHs.

If you have any questions, your staff may contact me or Aldo Marin, Board Relations Manager, at (213) 351-5530.

PLB:EM:KR
RDS:PBG:jlh

Attachments

c: William T Fujioka, Chief Executive Officer
Wendy L. Watanabe, Auditor-Controller
Jerry E. Powers, Chief Probation Officer
Public Information Office
Audit Committee
Sybil Brand Commission
Dana Anthony "Tony" Walker, President and Chief Executive Officer, St. Anne's Maternity Group Home
Lenora Scott, Regional Manager, Community Care Licensing
Angelica Lopez, Acting Regional Manager, Community Care Licensing

ST. ANNE'S MATERNITY GROUP HOME
CONTRACT COMPLIANCE MONITORING REVIEW SUMMARY

155 N. Occidental Blvd.
Los Angeles, CA 90026
License # 191802087
Rate Classification Level: 12

	Contract Compliance Monitoring Review	Findings: October 2013
I	**Licensure/Contract Requirements** (9 Elements)	
	1. Timely Notification for Child's Relocation	1. Full Compliance
	2. Provided Children's Transportation Needs	2. Full Compliance
	3. Vehicle Maintained In Good Repair	3. Improvement Needed
	4. Timely, Cross-Reported SIRs	4. Improvement Needed
	5. Disaster Drills Conducted & Logs Maintained	5. Full Compliance
	6. Runaway Procedures	6. Full Compliance
	7. Comprehensive Monetary and Clothing Allowance Logs Maintained	7. Full Compliance
	8. Detailed Sign In/Out Logs for Placed Children	8. Full Compliance
	9. CCL Complaints on Safety/Plant Deficiencies	9. Improvement Needed
II	**Facility and Environment** (5 Elements)	
	1. Exterior Well Maintained	Full Compliance (ALL)
	2. Common Areas Well Maintained	
	3. Children's Bedrooms Well Maintained	
	4. Sufficient Recreational Equipment/Educational Resources	
	5. Adequate Perishable and Non-Perishable Foods	
III	**Maintenance of Required Documentation and Service Delivery** (10 Elements)	
	1. Child Population Consistent with Capacity and Program Statement	1. Full Compliance
	2. County Children's Social Worker's Authorization to Implement NSPs	2. Improvement Needed
	3. NSPs Implemented and Discussed with Staff	3. Full Compliance
	4. Children Progressing Toward Meeting NSP Case Goals	4. Full Compliance
	5. Therapeutic Services Received	5. Full Compliance
	6. Recommended Assessment/Evaluations Implemented	6. Full Compliance
	7. County Children's Social Worker's Monthly Contacts Documented	7. Improvement Needed
	8. Children Assisted in Maintaining Important Relationships	8. Full Compliance
	9. Development of Timely, Comprehensive Initial	9. Improvement Needed

	NSPs with Child's Participation 10. Development of Timely, Comprehensive, Updated NSPs with Child's Participation	10. Improvement Needed
IV	**Educational and Workforce Readiness** (5 Elements) 1. Children Enrolled in School Within Three School Days 2. GH Ensured Children Attended School and Facilitated in Meeting Their Educational Goals 3. Current Report Cards/ Progress Reports Maintained 4. Children's Academic or Attendance Increased 5. GH Encouraged Children's Participation in YDS or Equivalent Services and Vocational Programs	Full Compliance (ALL)
V	**Health and Medical Needs** (4 Elements) 1. Initial Medical Exams Conducted Timely 2. Follow-Up Medical Exams Conducted Timely 3. Initial Dental Exams Conducted Timely 4. Follow-Up Dental Exams Conducted Timely	Full Compliance (ALL)
VI	**Psychotropic Medication** (2 Elements) 1. Current Court Authorization for Administration of Psychotropic Medication 2. Current Psychiatric Evaluation Review	Full Compliance (ALL)
VII	**Personal Rights and Social/Emotional Well-Being** (13 Elements) 1. Children Informed of Group Home's Policies and Procedures 2. Children Feel Safe 3. Appropriate Staffing and Supervision 4. GH's Efforts to Provide Nutritious Meals and Snacks 5. Staff Treat Children with Respect and Dignity 6. Appropriate Rewards and Discipline System 7. Children Allowed Private Visits, Calls and Correspondence 8. Children Free to Attend or Not Attend Religious Services/Activities 9. Children's Chores Reasonable 10. Children Informed About Their Medication and Right to Refuse Medication 11. Children Free to Receive or Reject Voluntary Medical, Dental and Psychiatric Care 12. Children Given Opportunities to Plan Activities in	1. Full Compliance 2. Full Compliance 3. Full Compliance 4. Improvement Needed 5. Full Compliance 6. Full Compliance 7. Full Compliance 8. Full Compliance 9. Full Compliance 10. Full Compliance 11. Full Compliance 12. Full Compliance

	Extra-Curricular, Enrichment and Social Activities (GH, School, Community) 13. Children Given Opportunities to Participate in Extra-Curricular, Enrichment and Social Activities (GH, School, Community)	13. Full Compliance
VIII	**Personal Needs/Survival and Economic Well-Being** (7 Elements) 1. $50 Clothing Allowance 2. Adequate Quantity and Quality of Clothing Inventory 3. Children Involved in Selection of Their Clothing 4. Provision of Clean Towels and Adequate Ethnic Personal Care Items 5. Minimum Monetary Allowances 6. Management of Allowance/Earnings 7. Encouragement and Assistance with Life Book/Photo Album	Full Compliance (ALL)
IX	**Discharged Children** (3 Elements) 1. Children Discharged According to Permanency Plan 2. Children Made Progress Toward NSP Goals 3. Attempts to Stabilize Children's Placement	Full Compliance (ALL)
X	**Personnel Records** (7 Elements) 1. DOJ, FBI, and CACIs Submitted Timely 2. Signed Criminal Background Statement Timely 3. Education/Experience Requirement 4. Employee Health Screening/TB Clearances Timely 5. Valid Driver's License 6. Signed Copies of Group Home Policies and Procedures 7. All Required Training	1. Full Compliance 2. Full Compliance 3. Full Compliance 4. Improvement Needed 5. Full Compliance 6. Full Compliance 7. Full Compliance

ST. ANNE'S MATERNITY GROUP HOME
CONTRACT COMPLIANCE MONITORING REVIEW
FISCAL YEAR 2013-2014

SCOPE OF REVIEW

The following report is based on a "point in time" monitoring visit. This compliance report addresses findings noted during the October 2013 review. The purpose of this review was to assess St. Anne's Maternity Group Home's (the Group Home) compliance with its County contract and State regulations and included a review of the Group Home's program statement, as well as internal administrative policies and procedures. The monitoring review covered the following 10 areas:

- Licensure/Contract Requirements,
- Facility and Environment,
- Maintenance of Required Documentation and Service Delivery,
- Educational and Workforce Readiness,
- Health and Medical Needs,
- Psychotropic Medication,
- Personal Rights and Social Emotional Well-Being,
- Personal Needs/Survival and Economic Well-Being,
- Discharged Children, and
- Personnel Records.

For the purpose of this review, six Department of Children and Family Services (DCFS) Children and one Department of Probation placed youth were selected for the sample. Out-of-Home Care Management Division (OHCMD) interviewed each child and reviewed their case files to assess the care and services they received. Additionally, four discharged children's files were reviewed to assess the Group Home's compliance with permanency efforts. At the time of the review, one child was prescribed psychotropic medication. OHCMD reviewed her case files to assess for timeliness of Psychotropic Medication Authorizations and to confirm the required documentation of psychiatric monitoring.

OHCMD reviewed five staff files for compliance with Title 22 Regulations and County contract requirements, and conducted a site visit to assess the provision of quality of care and supervision.

CONTRACTUAL COMPLIANCE

OHCMD found the following four areas out of compliance.

Licensure/Contract Requirements

- Although vehicle maintenance records showed that the Group Home's six vehicles in which, children are transported had been serviced regularly, one of the vehicles was not maintained in good condition. The door panel on the 1995 White Ford Aerostar's sliding door was broken and needed to be repaired. The Group Home immediately addressed the noted deficiency by

suspending the use of this vehicle until the repair was made. The Group Home's Residential Services Director stated that if the parts could not be ordered, the Group Home will no longer use this vehicle. Currently, Residential Staff is utilizing the five other vehicles to transport residents to school, activities, shopping, etc.

- It was noted that, although Special Incident Reports (SIRs) were properly documented, 36 SIRs were not submitted via ITrack timely or cross-reported to all required parties. The Group Home's Residential Services Director stated that the Residential Counselors who are responsible for inputting all reportable incidents are responsible for too many assignments, and therefore can not fully focus on submitting SIRs timely. In order to ensure that SIRs are submitted timely, the Group Home reassigned job duties; the Lead Program Assistant is responsible for inputting SIRs. In addition, the Senior Director of Residential Program and Support Services will review and submit all SIRs on a daily basis. Further, in the event that the Senior Director of Residential Programs and Support Services are unable to submit SIRs, the Senior Director of Community Based Services will review and submit SIRs to ensure that all SIRs are submitted timely and cross-reported to all required parties.

- Community Care Licensing (CCL) cited the Group Home as a result of deficiencies and findings noted during investigations. On May 29, 2013, CCL substantiated Personal Rights violations, as staff entered a child's bedroom, removed mail she had received from a hospital, made a copy and returned it without the child's consent. The Group Home immediately retrained the staff in effort to ensure that staff does not violate the children's personal rights. A written Plan of Corrective Action (POC) was submitted to CCL. CCL approved the POC and the citation was cleared by CCL on October 25, 2013.

  On June 3, 2013, CCL cited the Group Home as a result of a substantiated general neglect allegation, as staff placed a non-dependent child on the bed to change her diaper or clothes and the child rolled over and fell to the floor. The child sustained three red marks on her face which faded away shortly after; one underneath the eye, one above her eye and one on the side of her face. The Group Home retrained the staff on the program's policies and procedures to ensure the proper care and supervision of all children in placement. Staff will closely monitor children, including non-dependent children of residents, while under their supervision. CCL requested a POC and the Group Home timely submitted the POC and it was approved by the CCL. The citation was cleared by CCL on June 10, 2013.

Recommendation

The Group Home's management shall ensure that:

1. All vehicles in which children are transported are maintained in good condition.

2. SIRs are cross-reported to all required parties via ITrack, in a timely manner.

3. The Group Home is in compliance with Title 22 Regulations and County contract requirements.

Maintenance of Required Documentation and Service Delivery

- The Children's Social Worker's (CSW) or Deputy Probation Officer's (DPO) authorization to implement the Needs and Services Plan (NSP) were not obtained in a timely manner for 9 of 20 NSPs reviewed. The Residential Services Director stated that, in order to ensure DCFS CSW's or DPO's authorization is timely obtained, the Group Home will e-mail, fax or mail the NSP to DCFS CSW or DPO at least five days prior to the due date of each NSP. If the DCFS CSW or DPO has any concerns or requests changes to the NSP, the Group Home will make the changes and the NSP will be re-submitted to the CSW or DPO for authorization. If no changes are necessary, the Group Home will request that the DCFS CSW or DPO sign the signature page of the NSP and return it to the Group Home promptly via fax or mail. The Group Home will document all efforts made to obtain the DCFS CSW's of DPO's authorization to implement NSPs.

- Seven children's files were reviewed; six files did not include monthly contact notes with the children's DCFS CSW or DPO. During the Exit Conference, the Residential Services Director stated that a new form, the CSW or DPO Monthly Communication Log, has been developed and it will be utilized to document all contacts with the CSWs or DPOs, and it will be retained in the residents' files.

- Five initial NSPs were reviewed. The NSPs were timely; however, one was not comprehensive. The means by which the Group Home indicated it will measure the child's educational treatment goal was contradictory and not consistent with the method listed. Specifically, the treatment goal indicated that the child would attend school 4 out of 5 days per week in the initial NSP; but the method indicated that the child would attend school 3 out of 4 days per week.

- Fifteen updated NSPs were reviewed. The updated NSPs were timely; however, none were comprehensive. These NSPs did not include all the required elements, in accordance with the NSP template. All 15 NSPs did not include child's mental health outcome and follow-up information. One NSP did not include the Probation Criminogenic Factors Assessment information. Six updated NSPs did not include the dates of the Group Home monthly contacts with the DCFS CSWs or DPOs. In addition, three NSPs did not include concurrent permanency treatment goals; one NSP had incorrect SIR information; and two NSPs did not have measurable treatment goals.

It should be noted that the Group Home representatives attended the OHCMD's NSP Refresher Training on August 1, 2013. The NSPs reviewed had been developed prior to the August 2013 training. OHCMD provided NSP training to the Group Home's Treatment Team on October 30, 2013. During the Exit Conference, the Group Home's Residential Services Director stated that effective immediately, all NSPs will be reviewed by the Residential Services Director prior to submission to the DCFS CSW or DPO. The Group Home's Peer Review Team and the Quality Assurance section will ensure NSPs are properly prepared and include detailed information.

Recommendations

The Group Home's management shall ensure that:

4. The Group Home staff obtain, or document efforts to timely obtain, the DCFS CSW's or DPO's authorization to implement the NSP.

5. Monthly contacts with CSWs or DPOs are appropriately documented.

6. Comprehensive initial NSPs are developed and include all required elements in accordance with the NSP template.

7. Comprehensive updated NSPs are developed and include all required elements in accordance with the NSP template.

Personal Rights and Social/Emotional Well-Being

- Two of the seven children interviewed expressed concerns over the Group Home's food services. Both children informed OHCMD that they were not provided with sufficient amounts of food. They expressed that food runs out quickly at meal time. Staff has contacted the cafeteria and was informed that there was no additional food available. During the last annual review, there were complaints related to food services, but of a different nature. Previously, the concerns were related to the quality and cleanliness of food served at the Group Home. That issue has since been addressed and a new food vendor was hired. Now, that the quality of the food has improved, some children are taking a greater portion of the food, leaving the other children with less. The Group Home Residential Services Director stated that effective immediately, the Food Services Manager will call the Program Assistant on a daily basis, two hours before every meal, to obtain a count of the number of residents and staff in-house that will be present at meal time. In addition, the Food Services Manager will ensure approximately 10% more food will be added to the meal count. Further, the Residential Staff will participate in family style meals with residents to ensure that each resident receives a sufficient amount of food. OHCMD will follow up on this issue to ensure timely resolution during our next visit to the Group Home.

Recommendations

The Group Home's management shall ensure that:

8. All children receive a sufficient amount of quality food and nutritious meals.

Personnel Records

- One staff member did not receive timely health screening. Her health screening was eight months late. The Residential Services Director stated that in the future, all new staff will complete health screenings and tuberculosis (TB) tests prior to employment with the Group Home, or they will not be permitted to report to work. This staff completed the required health screening with valid TB clearances on October 17, 2013. OHCMD received verification of the updated health records and a copy was placed in the employee's personnel file.

The Group Home's management shall ensure that:

9. All employees receive timely health screenings and TB clearances.

PRIOR YEAR FOLLOW-UP FROM DCFS OHCMD's GROUP HOME CONTRACT COMPLIANCE MONITORING REVIEW

The OHCMD's last compliance report, dated August 2, 2013, identified 14 recommendations.

Results

Based on our follow-up, the Group Home fully implemented 8 of 14 recommendations for which they were to ensure that:

- The Group Home maintains sufficient recreational equipment and appropriate educational resources and supplies in good working condition and readily available to children,
- All placed children are progressing toward meeting their NSP goals,
- Children improve academic performance and/or school attendance,
- The Group Home facilitates age-appropriate children's participation in YDS or equivalent services and vocational training programs,
- All children are given opportunities to plan in age-appropriate, extra-curricular, enrichment, and social activities in which they have an interest, at school, in the community or at the group home,
- All children are given opportunities to participate in age-appropriate, extra-curricular, enrichment, and social activities in which they have an interest, at school, in the community or at the group home,
- All children are encouraged and assisted in updating their life book or photo album, and
- All discharged children make progress toward meeting their NSP goals.

The Group Home did not implement six recommendations for which they were to ensure that:

- SIRs are appropriately documented and cross-reported to all required parties via ITrack, in a timely manner,
- The group home is in compliance with Title 22 Regulations and County contract requirements,
- Comprehensive initial NSPs are developed and include all required elements in accordance with the NSP template,
- Comprehensive updated NSPs are developed and include all required elements in accordance with the NSP template,
- All children receive good quality and quantity, nutritious meals and snacks, and
- Full implementation of the outstanding recommendations from the OHCMD's prior monitoring report, as the Group Home did not timely obtain the DCFS CSWs' or DPO's authorization to implement the NSP, children did not receive sufficient serving of food and snacks, and NSPs were not comprehensive.

Recommendation

The Group Home's management shall ensure that:

10. The outstanding recommendations from the 2012-2013 monitoring report, dated August 3, 2013, which are noted in this report as Recommendations 2, 3, 5, 6, 7, 8, and 10 are fully implemented.

During the Exit Conference, the Group Home representatives expressed their desire to remain in compliance with all Title 22 Regulations and Contract requirements. In efforts to ensure the development of comprehensive NSPs, the Group Home's Residential Services Director will review all NSPs prior to submission to the DCFS CSW or DPO. The Peer Review Team and the Quality Assurance section will ensure NSPs are properly developed and include detailed information. Further, the Lead Program Assistant will assume the responsibility of inputting SIRs instead of Residential Counselor to ensure all SIRs are submitted timely and cross-reported to all parties. Additionally, the Group Home will add approximately 10% additional food to the meal count to ensure that all children receive sufficient quality, nutritious meals. The Group Home's Residential Services Director and the Quality Assurance Director will conduct period checks to monitor compliance with the CAP. OHCMD will visit the Group Home in March 2014 to provide the Group Home with technical assistance and follow-up on the implementation of the recommendations.

MOST RECENT FISCAL REVIEW CONDUCTED BY THE AUDITOR-CONTROLLER

The Auditor-Controller conducted a review of the Group Home's fiscal operations from January 1, 2010 to December 31, 2010. The fiscal report, dated January 17, 2013, states the Group Home had no unallowable or questioned costs. However, the Group Home needs to strengthen its controls over petty cash, vehicle mileage logs, fixed assets, and payroll/personnel records. The Group Home submitted an approved fiscal Corrective Action Plan on July 19, 2012 in response to the fiscal audit.

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St Anne's

Brighter futures for at-risk pregnant young women, mothers and children

November 26, 2013

Patricia Bolanos-Gonzalez, Manager
County of Los Angeles
Department of Children and Family Services
Out of Home Care Management Division
Group Home Monitoring Section
9320 Telstar Avenue, Suite 216
El Monte, CA 91731

RE: Corrective Action Plan for Group Home Monitoring Review
Site Visit Date: October 15, 2013
CAP Due Date: November 29, 2013

Dear Ms. Bolanos-Gonzalez:

The St. Anne's Residential Treatment Program is dedicated to providing the best services available to our residents. Your collaboration and input is helpful in making this possible for our residents. The following items were recommended and will be rectified through the plans related below.

I. LICENSURE/CONTRACT REQUIREMENT

Element #3:

Finding: One of the six vans used to transport residents was cited for maintenance repair of the interior passenger panel.

Corrective Action Plan:

The last time residents were transported with 1995 White Ford Aerostar was on 10/08/13. The van will not be in operation until the mechanical issue is addressed. Residential Staff will utilize five other vans to transport residents to school, activities, shopping, etc. The following routine is completed on a daily basis to maintain vehicle:

a) St. Anne's Maintenance staff will complete a vehicle inspection on a daily basis on all vans which is tracked on the Vehicle Inspection Form. **(Please see Attachment 1)**

b) In the event that a maintenance repair is evident, maintenance staff will place the van out of commission and repair vehicle before placing it back in operation.

c) Residential Staff will also complete a Vehicle Inspection Log of Vans signed out to them on a daily basis. All issues related to the vehicle will be communicated to the Milieu Managers who will submit a work order request to repair the vehicle.

Implementation Date: 11/26/13 and Ongoing

155 N. Occidental Boulevard, Los Angeles, CA 90026 *tel* 213.381.2931 *fax* 213.381.7804 stannes.org

Person Responsible:	Residential Treatment Program Director Milieu Managers Residential Staff Maintenance Staff
Quality Assurance:	Quality Assurance Director

Element #4:
Finding: Not all Significant Incident Reports (SIRs) were submitted timely and cross reported to the right personnel.

Corrective Action Plan:
SIRs will be submitted in a timely manner and reviewed to ensure that all parties are appropriately cross reported.

a) During the weekdays, the inputting of SIR on I-track has been reassigned to the Lead Program Assistant instead of Lead Residential Counselors, Managers, and Assistant Directors. The Lead Program Assistant will notify Residential Treatment Program Director and Senior Director of Residential Programs once I-track has been saved for review and submittal.
b) Residential Treatment Program Director will review all SIR's on a daily basis and notify Senior Director of Residential Program of completion.
c) Senior Director of Residential Program and Support Services will review and submit all SIR's on a daily basis.
d) In the event that the Senior Director of Residential Programs and Support Services is not able to submit SIRs, the Senior Director of Community Based Services will review and submit SIRs.

For Immediate SIR I-track submittal (such as: runaways and hospitalization):

e) Managers will immediately submit all runaway and hospitalization I-tracks and will addendum runaway I-tracks when necessary. Assistant Directors will review submitted I-track to ensure accuracy. Managers were trained on 08/28/13 on appropriately completing and submitting immediate SIR I-tracks.
f) Assistant Directors will input SIRs on I-track on weekends and will notify Residential Treatment Program Director and Senior Director of Residential Programs once I-track has been saved for review and submittal.
g) In the event that the Senior Director of Residential Programs and Support Services is not able to submit SIRs, the Senior Director of Community Based Services will review and submit SIRs.

Implementation Date:	11/26/13 and Ongoing
Person Responsible:	Senior Director of Residential Programs and Support Services Senior Director of Community Based Programs Residential Treatment Program Director Residential Program Assistant Directors Lead Program Assistant Managers Lead Residential Counselors
Quality Assurance:	Quality Assurance Director

Element #9
Finding #1: Community Care Licensing (CCL) Deficiencies – CCL cited St. Anne's Maternity Home on May 29, 2013 for "opening resident's mail." On 01/16/13, staff made a copy of an open

mail to obtain medical follow-up instructions and filed the medical copy in resident's medical chart without obtaining resident's prior approval.

Corrective Action Plan:
Residents Personal Rights will not be violated.

a) All staff is trained on Title 22 Regulations, The Foster Youth Bill of Rights during new hire orientation and annually.

b) A Corrective Action Plan (CAP) was re-submitted to CCL on 06/05/13 regarding this issue.

c) The CAP was cleared by CCL on 10/25/13

Implementation Date:	Immediately and Ongoing
Person Responsible:	Residential Treatment Program Director Residential Program Assistant Directors Residential Staff
Quality Assurance:	Quality Assurance Director

Finding #2: CCL Deficiencies – CCL cited St. Anne's Maternity Home on June 3, 2013 for "Monitoring and Supervision." On February 8, 2012, a resident's child fell off the bed while under the care and supervision of staff. Staff was changing resident child's diaper on the bed and when staff turned around to look for a change of clothes, the child fell off the bed.

Corrective Action Plan:
Staff will maintain constant supervision of child/ren while in staffs care, including not leaving a child unattended on high surfaces.

a) Staff will closely monitor child/children of residents while under their supervision, and child/ren will be within an arm's length of staff.
b) A Corrective Action Plan was submitted to CCL on 06/06/13 regarding this issue.
c) The CAP was cleared by CCL on 06/10/13

Implementation Date:	Immediately and Ongoing
Person Responsible:	Residential Treatment Program Director Residential Program Assistant Directors Residential Staff
Quality Assurance:	Quality Assurance Director

II. FACILITY AND ENVIRONMENT

No findings noted in this area during this review

III. MAINTENANCE OF REQUIRED DOCUMENTATION AND SERVICE DELIVERY

Element #16

Finding: Group Home staff did not obtain or document efforts to obtain County Worker's authorization to implement the Needs and Services Plans (NSPs) on a timely manner.

Corrective Action Plan:

a) The Education Case Liaison (ECL) will e-mail, fax or mail the NSP to Department of Children and Family Social Worker (DCFS) County Social Worker (CSW) or Department of Probation Officer (DPO) at least five days prior to the due date of each NSP.
b) If the DCFS CSW or DPO has any concerns or requests changes to the NSP, the ECL will make the changes and the NSP will be re-submitted to the CSW or DPO for authorization.

c) If no changes are necessary, the ECL will request that the DCFS CSW or DPO sign the signature page of the NSP and return it via fax or mail. The ECL will document all efforts made to obtain the DCFS CSW's of DPO's authorization to implement NSP's.

Implementation Date:	11/26/13 and Ongoing
Person Responsible:	Residential Treatment Program Director Residential Program Assistant Directors Education Case Liaisons
Quality Assurance:	Quality Assurance Director

Element #21
Finding: Monthly Contacts with St. Anne's ECL and CSW were not appropriately documented in case file.

Corrective Action Plan:

a) ECLs will track monthly contact with DCFS CSWs or DPOs on the Contact Sheet Form which will be turn in monthly to the Assistant Director during document collection. **(Please see Attachment 2)**
b) This form once completed will be retained in the residents' files.

Implementation Date:	11/26/13 and Ongoing
Person Responsible:	Residential Treatment Program Director Residential Program Assistant Directors Education Case Liaisons
Quality Assurance:	Quality Assurance Director

Element #23 and #24
Finding: NSP were not comprehensive due to the following reasons:

- Fifteen NSPs did not include mental health's outcome and follow up information
- One NSP did not include the Probation LARRC Assessment information
- Not all treatment goals were measurable
- Three NSPs did not include concurrent permanency treatment goals.
- One NSP had the wrong SIR information
- Six NSPs did not provide CSW monthly contact dates
- All updated NSPs reviewed needed to be more child specific
- All updated NSPs reviewed needed to provide more detailed ILP information

Corrective Action Plan:
Group Home representatives attended the OHCMD's NSP Refresher Training on August 1, 2013. The Group Home OHCMD provided NSP training to the Group Home's Treatment Team on October 30, 2013.

The following steps will take place to ensure that NSPs are comprehensive:
All goals on NSPs will be individualized to each client based on baseline behaviors presented at intake.

a) A comprehensive psycho-social assessment is completed upon intake.
b) Over the first 30 days of placement, each resident is assessed and participates in a Managing and Adaptive Practices (Evidence Based Practice-EBP) Self-Sufficiency Meeting to create individualized goals.
c) St. Anne's unifying EBPs are Managing and Adaptive Practices, Nurturing Parenting,

and Seeking Safety. These EBPs are used in collaboration with Therapist, Residential Staff, other staff involved with the client, and Resident.

d) During the self-sufficiency meetings, goals are created with the input of the resident to assist resident in making progress in their permanency plan. The Education Case Liaisons (ECLs) will ensure that the NSP goals are S.M.A.R.T. and completed in accordance to deadlines.
e) As an internal process, the ECLs will update all NSPs on a monthly basis, which will be reviewed by the supervising Assistant Director. This will ensure that all NSP are completed on time.
f) In the event that an ECL resigns, an Assistant Director will complete NSPs as needed until position has been filled and the new ECL is trained on effectively completing NSPs.

Training

a) During interviews, potential ECL candidate will be required to write a sample goal.
b) Upon new hire, ECLs will be trained on creating S.M.A.R.T. goals and will be asked to complete a post test.

Quality Improvement

c) ECLs will track monthly contact with social workers on the NSPs.
d) The Assistant Director who oversees the ECL will review each completed NSPs monthly to ensure that the document is comprehensive and includes all the information listed above.
e) The Director will review initial and quarterly NSPs with the Assistant Director to ensure that the documents are comprehensive and includes all the required information.
f) All charts will be submitted through a Performance Quality Improvement Process and reviewed by a Peer Review Team to ensure comprehensiveness of NSPs.

Implementation Date:	11/26/13 and Ongoing
Person Responsible:	Residential Treatment Program Director Residential Program Assistant Directors Education Case Liaisons Peer Review Team
Quality Assurance:	Quality Assurance Director

IV. EDUCATION AND WORKFORCE READINESS

No findings noted in this area during this review.

V. HEALTH AND MEDICAL NEEDS

No findings noted in this area during this review.

VI. PSYCHOTROPIC MEDICATION

No findings noted in this area during this review.

VII. PERSONAL RIGHTS AND SOCIAL/EMOTIONAL WELL-BEING

Element #39

Finding: Residents expressed concerns of not having enough food and when cafeteria is called, and staff is informed that there is no more food available.

Corrective Action Plan:

a) Food Services Manager will call the Program Assistant on a daily basis two hours before every meal services to get a count of how many residents and staff are in-house.

b) In addition, the Food Services Manager provides approximately 10% of additional food to the meal count.
c) Residential Staff participate in family style meals with residents to ensure that each resident is provided an equal share of food.

Implementation Date:	11/26/13 and Ongoing
Person Responsible:	Residential Treatment Director Milieu Manager Program Assistant Food Services Manager
Quality Assurance:	Quality Assurance Director

VIII. PERSONAL NEEDS/SURVIVAL AND ECONOMIC WELL-BEING

No Findings noted in this area during this review.

IX. DISCHARGED CHILDREN

No Finding noted in this area during this review.

X. PERSONNEL RECORDS

Element #62

Finding: One staff did not receive their Initial Health Screening upon hire date.

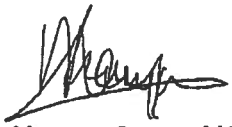
Corrective Action Plan:

a) All potential New Hires will complete a Pre-employment health screening and Tuberculosis (TB) test prior to employment with the Group Home.
b) The potential New Hire will not be permitted to report to work without the clearance of the health screening.
c) The Human Resource Coordinator will obtain clearance record and keep it in the employee's personal file.

Implementation Date:	11/26/13 and Ongoing
Person Responsible:	Human Resource Coordinator
Quality Assurance:	Quality Assurance Director

If you have any questions, please don't hesitate to contact me directly at (213) 381-2931 ext. 264 or Carlos Tobar, Quality Assurance Director at ext. 500.

Sincerely,



Maryam Sesay, MSHA
Residential Treatment Program Director

cc: Tony Walker, President and Chief Executive Officer
Sharon Spira-Cushnir, Chief Operating Officer
Lauri Collier, Senior Director of Residential Programs & Support Services
Carlos Tobar, Quality Assurance Director