County of Los Angeles
DEPARTMENT OF CHILDREN AND FAMILY SERVICES
425 Shatto Place, Los Angeles, California 90020
(213) 351-5602

PHILIP L. BROWNING
Director

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March 2, 2016

To: Supervisor Hilda L. Solis, Chair
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From: Philip L. Browning
Director

OLIVE CREST TREATMENT CENTERS DBA OLIVE CREST FISCAL ASSESSMENT AND CONTRACT COMPLIANCE MONITORING REVIEW

The Department of Children and Family Services (DCFS) Contracts Administration Division (CAD) conducted a Fiscal Compliance Assessment and Contract Compliance Review of Olive Crest Treatment Centers dba Olive Crest (the Group Home) in May 2015. The Group Home has one site in the Fourth Supervisorial District and provides services to the County of Los Angeles DCFS placed children and Probation foster youth. According to the the Group Home's Program Statement, its stated purpose is "to provide a long term, safe, structured and therapeutic environment for adolescents with a history of severe problems."

The Agnecy has a 6-bed site licensed to serve a capacity of six male children, ages 13-21. At the time of review, the Group Home served three placed DCFS placed children and three children placed through Orange County. The placed children's overall average length of placement was eight months, and their average age was 17.

SUMMARY

CAD conducted a Fiscal Compliance Assessment, which included an agency-wide review of the Group Home's financial records, such as financial statements, bank statements, check register and personnel files to determine the Group Home's compliance with the terms, conditions and requirements of Agency's contract, Foster Family Agency contract, the Auditor-Controller Contract Accounting and Administration Handbook (A-C Handbook) and other applicable federal, State, and County regulations and guidelines.

The Group Home was in full compliance with 4 of 5 areas of the Fiscal Compliance Assessment: Financial Overview; Loans, Advances and Investments; Board of Directors and Business Influence; and Payroll and Personnel.

CAD noted deficiencies in the area of Cash/Expenditures, related to the fixed assets inventory list, which did not have the funding source.

During CAD's Contract Compliance 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 dignity and respect.

The Group Home was in full compliance with 7 of 10 sections of our contract compliance review: Facility and Environment, Education and Workforce Readiness, Health and Medical Needs, Personal Rights and Social/Emotional Well-Being, Personal Needs/Survival and Economic Well-Being, Discharged Children, and Personnel Records.

CAD noted deficiencies in the areas of: Licensure/Contract Requirements, related to SIRs not timely reported and cross-reported; Maintenance of Required Documentation and Service Delivery, related to not obtaining the County social worker's authorization on the Needs and Services Plans (NSP), not implementing and discussing an NSP with the Group Home staff, not contacting County workers monthly and documenting contacts in case files and not developing comprehensive updated NSPs; and Psychotropic Medication, related to not having current court approved authorizations for the administration of psychotropic medication.

Attached are the details of our review.

REVIEW OF REPORT

On July 15, 2015, Sherry L. Rolls, CAD held an Exit Conference with the Group Home staff Xavier Floyd, Residential Manager and Kristen Spence, Case Manager. DCFS staff included Sonya Noil, Out-of-Home Care Management. On October 2, 2015, Joe Jimenez Jr., CAD Fiscal, held the Fiscal Exit Conference with the Group Home staff Cindy Long, Controller and Justin Laird, Accounting Manager.

The Group Home's representatives agreed with the review findings and recommendations, were receptive to implementing systematic changes to improve the Group Home's compliance with regulatory standards, and were in agreement with addressing the noted deficiencies in compliance with the Corrective Action Plan (CAP) and a Fiscal Corrective Action Plan (FCAP).

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 and FCAP addressing the recommendations noted in this report.

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

PLB:EM:LTI:slr

Attachments

c: Sachi A. Hamai, Chief Executive Officer
John Naimo, Auditor-Controller
Calvin Remington, Interim Chief Probation Officer
Public Information Office
Audit Committee
Sybil Brand Commission
Donald A. Verleur II, MBA, Executive Director, Olive Crest Treatment Centers
Lajuannah Hills, Regional Manager, Community Care Licensing Division
Lenora Scott, Regional Manager, Community Care Licensing Division

OLIVE CREST TREATMENT CENTERS
FISCAL COMPLIANCE ASSESSMENT REVIEW
FISCAL YEAR 2015 – 2016

SCOPE OF REVIEW

The Fiscal Compliance Assessment included a review of Olive Crest Treatment Centers' (the Agency's) financial records for the period of July 1, 2013 through July 31, 2015. The Contracts Administration Division (CAD) reviewed the financial statements, bank statements, check register, and personnel files to determine the Agency's compliance with the terms, conditions and requirements of the following DCFS Contracts: Child Abuse Prevention Intervention and Treatment; Adoption Promotion and Support Services; Foster Family Agency (FFA); FFA-Emergency Shelter Care; Intensive Treatment Foster Care; FFA; Agency; Transitional Housing Placement Program; Transitional Housing Program Plus Foster Care and Wraparound Approach Services Contracts. The Auditor-Controller Contract Accounting and Administration Handbook (A-C Handbook) and other applicable federal, State, and County regulations and guidelines.

The on-site Fiscal Compliance Assessment review focused on five key areas of internal controls:

- Financial Overview,
- Loans, Advances and Investments,
- Board of Directors and Business Influence,
- Cash/Expenditures, and
- Payroll and Personnel.

The Agency was in full compliance with 4 of the 5 areas of the Fiscal Compliance Assessment: Financial Overview; Loans, Advances and Investments; Board of Directors and Business Influence; and Payroll and Personnel.

FISCAL COMPLIANCE

CAD found the following area out of compliance:

Cash/Expenditures

- The fixed assets inventory list missing funding source information.

The Agency will modify the fixed assets inventory list to include the funding effective July 1, 2015.

RECOMMENDATION:

The Agency's management shall ensure that:

1. The fixed assets inventory must include all required elements.

MOST RECENT FISCAL REVIEW CONDUCTED BY THE AUDITOR-CONTROLLER

The most recent fiscal review of the Agency was posted by the Auditor-Controller (A-C) on December 30, 2009 for Fiscal Year 2008-2009. The A-C review identified $506.00 in questioned Department of Mental Health (DMH) costs. The A-C recommended some process changes and that the Agency base payroll expenditures on the actual hours worked with timecards signed by both employee and supervisor. The A-C also recommended that the Agency implement two prior A-C recommendations. The $506.00 was repaid to DMH on March 6, 2010.

NEXT FISCAL COMPLIANCE ASSESSMENT

The next Fiscal Compliance Assessment of the Agency will be conducted in County Fiscal Year 2016-2017.

OLIVE CREST TREATMENT CENTERS DBA OLIVE CREST
CONTRACT COMPLIANCE REVIEW SUMMARY

License Number 197804913
Rate Classification Level: 14

	Contract Compliance Review	Findings: May 2015
I	**Licensure/Contract Requirements** (9 Elements)	
	1. Timely Notification for Child's Relocation	1. Full Compliance
	2. Transportation Needs Met	2. Full Compliance
	3. Vehicle Maintained In Good Repair	3. Full Compliance
	4. Timely, Cross-Reported SIRs	4. Needs Improvement
	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. Full Compliance
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. Improvement Needed
	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 Workers Monthly Contacts Documented	7. Improvement Needed
	8. Children Assisted in Maintaining Important Relationships	8. Full Compliance
	9. Development of Timely, Comprehensive Initial NSPs with Child's Participation	9. Full Compliance
	10. Development of Timely, Comprehensive, Updated NSPs with Child's Participation	10. Improvement Needed

IV	**Education 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 Performance and/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	1. Improvement Needed 2. Full Compliance
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 Reasonable Chores 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 Extra-Curricular, Enrichment and Social Activities (GH, School, Community)	Full Compliance (All)

	13. Children Given Opportunities to Participate in Extra-Curricular, Enrichment and Social Activities (GH, School, Community)	
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 the 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	Full Compliance (All)

PROJECT SIX GROUP HOME DBA THE HELP GROUP HOME
CONTRACT COMPLIANCE REVIEW
FISCAL YEAR 2014-2015

SCOPE OF REVIEW

The following report is based on a "point in time" visit. This compliance report addresses findings noted during the May 2015 review. The purpose of this review was to assess Project Six Group Home (the Group Home's) 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 compliance review covered the following 10 areas:

- Licensure/Contract Requirements,
- Facility and Environment,
- Maintenance of Required Documentation and Service Delivery,
- Education 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, four placed children were selected for the sample. The Contracts Administration Division (CAD) interviewed each child and reviewed their case files to assess the care and services they received. Additionally, three discharged children's files were reviewed to assess the Group Home's compliance with permanency efforts. At the time of the review, three of the sampled children were prescribed psychotropic medication. The children's case files were reviewed to assess for timeliness of Psychotropic Medication Authorizations and to confirm the required documentation of psychiatric monitoring.

CAD 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

CAD found the following three areas out of compliance:

Licensure/Contract Requirements

- A Special Incident Report (SIR) was not timely submitted.

1 of 19 SIRs reviewed determined that it was not timely submitted into the I-Track database.

During the review, the Group Home representative reviewed the SIR sampled and acknowledged the oversight related to timeliness. During a follow-up visit on September 9, 2015, CAD reviewed three additional SIRs and observed that each SIR was timely submitted. The Group Home's representative stated that on July 8, 2015 training was conducted on SIR and I-Track policies and procedures to all permanent staff. All SIRs will be submitted in a timely manner according to Community Care Licensing

was not submitted until October 16, 2015; a run-away incident took place on October 17, 2014 and was not submitted until October 21, 2014; an injury that took place on November 8, 2014 and was not submitted until November 12, 2014; a medical incident that took place on January 27, 2015 and was not submitted until February 5, 2015; a suicidal ideation incident that took place on April 21, 2015 and was not submitted until April 24, 2015; and a behavioral/mental health incident that took place on May 25, 2015 and not submitted until May 27, 2015.

Incidents that were not cross-reported to CCL were related to an assaultive behavior and run-away incidents that took place on May 18, 2014; a Behavioral/Mental Health incident that took place on June 2, 2014; and an Assaultive Behavior (Peer) incident that took place on April 16, 2015.

The two SIRs that were not submitted timely or properly cross-reported were related to a medical incident that took place on June 9, 2014 and was not submitted until June 15, 2014 and the other for runaway/self-injurious behavior that took place on October 17, 2014 and was not submitted until October 21, 2014.

Recommendation:

The Group Home's management shall ensure that:

1. SIRs are submitted timely and appropriately cross-reported.

Maintenance of Required Documentation and Service Delivery

- No documented efforts to obtain County Children's Social Worker's (CSW's) authorization to implement a Needs and Services Plans (NSP).

For one child there was no documented effort to obtain the County CSW's authorization to implement updated NSPs dated July 18, 2014, October 18, 2014 and January 18, 2015.

- An NSP was not implemented and discussed with the Group Home staff.

A child's July 18, 2014 NSP was not signed by the Group Home staff.

- County CSW's monthly contacts were not documented in the case file.

For one child no contact with the County CSW was noted in the child's case file for June and July 2014.

- Updated NSPs were not comprehensive.

For one child, four updated NSPs reviewed were not comprehensive, as they did not note psychiatric treatments the child received, reasons for modifying outcome goals and reasons for re-listing outcome goals the child had previously achieved.

For another child, three updated NSPs reviewed were not comprehensive as the Group Home filled out the Foster Family Agency portions of the NSP and there was no contact with the County CSW in the months of June and July 2014.

During the exit conference, the Group Home representatives acknowledged the need to improve documenting efforts to obtain County CSW's authorization to implement NSPs, having the Group Home staff review and sign NSPs, contacting the County CSW on a monthly basis and properly documenting those efforts and ensuring updated NSPs are comprehensive.

Recommendations:

The Group Home's management shall ensure that:

2. Document efforts to obtain the County CSW's authorization to implement NSPs.

3. NSPs are implemented and discussed with the Group Home staff.

4. County CSWs are contacted monthly and contact is appropriately documented in the case file.

5. Develop comprehensive updated NSPs.

Psychotropic Medication

- No current court-approved authorization for the administration of psychotropic medication.

One child did not have a current court-approved authorization for psychotropic medications. The latest authorization in the child's case file included a stipulation for renewal in 45 days. The Group Home did not have a renewed authorization and the earliest efforts to obtain the renewed authorization was requested 7 days after the authorization expired.

Recommendation:

The Group Home's management shall ensure that:

6. Court-approved authorizations for the administration of psychotropic medications are current.

PRIOR YEAR FOLLOW-UP FROM DCFS CAD'S GROUP HOME CONTRACT COMPLIANCE REVIEW

CAD's last compliance report dated, December 31, 2014, identified eight recommendations.

Results:

Based on the results of the current review the Group Home implemented 6 of 8 recommendations for which they were to ensure that:

- Appropriate monetary and clothing allowance logs are maintained.

- The Group Home is in compliance with Title 22 regulations and free of CCL citations.
- Initial NSPs are comprehensive and developed timely.
- All placed children are enrolled in school in a timely manner.
- A current copy of valid driver licenses is maintained in the file of all its employees at all times.
- All staff receives the minimum required trainings timely.

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

- Monthly contact with the County Children's Social Workers is documented.
- Updated NSPs are comprehensive and developed timely.

Recommendation:

7. The outstanding recommendations from the 2013-2014 compliance report dated December 31, 2014, which are noted in this report as recommendations 4 and 5 are fully implemented.

At the Exit Conference, the Group Home representatives expressed their desire to remain in compliance with all Title 22 regulations and contract requirements and were in agreement with the findings and recommendations. The Group Home representatives stated the Group Home would implement procedures to strive towards greater compliance.

On November 10, 2015, CAD began its 2015-2016 Contract Compliance Monitoring Review to continue to assess implementation of the recommendations. Out-of-Home Care Management Division will provide ongoing support and technical assistance prior to the next review.

..FORTY YEARS..
OLIVE CREST
Strong Families, Safe Kids

1.800.550.CHILD (2445)
www.olivecrest.org

October 7, 2015

Joe Jimenez
Fiscal Compliance Administrator
Department of Children and Family Services
Contract Administration Division
3530 Wilshire Blvd, 5th Floor
Los Angeles, CA. 90010

RE: Fiscal Corrective Action Plan

To Whom It May Concern:

Recently a fiscal compliance assessment was conducted of our organization by the County of Los Angeles Department of Children and Family Services. During the subsequent Exit Conference on October 2, 2015 we were informed that a deficiency was noted and a finding was reported related to our fixed assets documentation, specifically that our fixed asset detail does not include the funding source for each asset. As a result of the identification of this finding we are required to submit this Fiscal Corrective Action plan describing our plan to address the deficiency.

We will be taking two correction actions relating to this finding. The first action is to update our "Financial Procedure for Capitalization and Depreciation of Assets" to include a section requiring inclusion of the funding source(s) whenever an asset is capitalized. The second action is to implement the procedure by including an additional column of data to reflect the funding source when the asset is initially recorded. The funding source will be available within the purchase order and check request documents currently used when the capitalization entry is processed. We have agreed to implement this procedure effective July 1, 2015 and thus will review all asset additions for the current fiscal year and add the additional information. This additional information will be captured as part of the monthly fixed asset reconciliation prepared by an accountant III employee and reviewed monthly by the accounting manager.

Please feel free to contact me at (657) 622-4133 or cindy-long@olivecrest.org if you have any questions.

Sincerely,

Cindy Long

Cindy Long
Controller

Cc: Ed Becker, CFO
Justin Laird, Accounting Manager

OLIVE CREST
Strong Families, Safe Kids

September 15, 2015

Department of Children & Family Services
12440 E. Imperial Hwy, Suite 537
Norwalk, CA 90650

Attn: Contract Compliance Monitoring

RE: **DCFS CONTRACT COMPLIANCE CORRECTIVE ACTION PLAN**

Dear Ms. S. Rolls:

Olive Crest seeks to address the Safety, Well-Being, & Permanency needs of the youth placed in our Bellflower RTC-14 program with excellence. Our team appreciates your department assistance in identifying areas for corrections or improvements. This letter is submitted with the intention of addressing those areas of needed improvement, and to define our plan to correct or prevent future deficiencies.

The following is in response to areas of Contract Compliance exit summary of July 15, 2015.

I. LICENSURE/CONTRACT REQUIREMENTS:

#4) The specific SIRs in question were not reported timely into the iTrack system:

Sometimes incidents requiring SIRs occur on the weekends or evenings when the Case Manager is off-duty, thus resulting in delayed entry of SIRs into the iTrack system. To reduce the delay and improve efficiency in this area, we began to train multiple staff to input SIR's into the iTrack system starting in September 2015.

Staff has been informed to notify Case Manager via telephone call or text when an SIR occurs so that it may be entered into the system in a timely manner. Staff were required to attend a scheduled in-service training which took place on 8/27/2015, during which staff were instructed to contact the Case Manager via phone call or text as soon as an SIR related incident occurs. The issue of what warrants writing an SIR was reviewed in this in-service, as well as the timely submittal of all SIRs. On-going training of new staff, and proper procedures for processing incident reports that occur over the weekend when Case Manager is not on-site, will continue throughout the year for current and newly hired staff to ensure consistency and timeliness of reporting SIRs.

There were five SIRs that were not properly cross-reported:

Prior communications with the CCL analyst indicated that they only wish to receive SIRs of a serious nature, such as AWOL, fights, sexual allegations, and medication errors, etc. However, the program leadership will consult with CCL to clarify cross-reporting requirements going forward.

Further, Clinical Case Manager will go back into the SIR once it has been submitted to ensure all required parties have been cross-referenced and SIR was submitted to each.

III. MAINTENANCE OF REQUIRED DOCUMENTATION AND SERVICE DELIVERY

#16) Did the group home obtain or document efforts to obtain the County Worker's authorization to implement the Needs and Service Plan?

No documentation efforts to have CSW to sign the following NSPs:

CSW signed NSP dated 10/15/14, 1/18/15 when required to do so. (Copies available upon request). CSW signed the NSP dated 7/18/14 on 6/30/14. However, Clinical Case Manager had the wrong date at the top of the NSP (4/18/14 when it should have been 7/18/14). From this date forward, Clinical Case Manager will check all dates on the NSP at the beginning of updating it and again at the conclusion to ensure the NSP maintains accurate dates to avoid any further confusion.

The Residential Manager, Clinical Case Manager, and Therapist will document every reasonable effort to make contact with CSWs (i.e., meetings, phone calls, emails) so that it is clear for our records and for NSP documentation. This will be done utilizing a phone log beginning November 10, 2015, which will detail the type of contact, date, time of contact, and the body of the conversation.

#17) Are NSP's implemented and discussed with the group home staff?

The Unit Therapist and/or Clinical Supervisor lead the discussion with group home staff regarding our initial and quarterly NSP reports, during our bi-weekly treatment team meetings. Our staff is a part of the treatment team which meets to discuss the progress in treatment, the strategies and interventions being utilized, and the overall well-being of each client. Detailed discussion of the client's current behaviors, school discipline, treatment objectives, doctor's appointments, and medication concerns, as well as their discharge plans, are formally conducted with staff and invited guests such as CSWs and DMH. Beginning August 27, 2015, the Therapist will be more deliberate in future treatment team meetings by clarifying NSP issues as they are discussed. At each treatment team meeting staff are provided with a Treatment Team Format detailing the various parts of the NSP to be discussed that day. This has always been our practice.

#21) Are County workers contacted monthly by the GH and are the contacts appropriately documented in the case file?

Generally, most CSW do contact their client monthly, however there are a limited few that fail to meet this responsibility. Regarding the client in question, the CSW did not visit or call the RTC during a two month period. Clinical Case Manager has

no record of emailing the CSW during those months and was not tracking phone contact at that time. Clinical Case Manager will document any attempts to contact CSW via phone and maintain a log of said attempts. This will be done via utilization of a phone log beginning November 10, 2015, which will detail the type of contact, date, and time of contact.

#24) Did the treatment team develop timely, comprehensive, updated NSP with the participation of the developmentally age-appropriated child?

NSPs which states that the "Client will receive ILP classes at group home and LST as they are offered through agencies on the weekends." However, case file includes training certificates received for period of May 5, 2014 – June 7, 2014 for all clients in our care.

Subsequent to our meeting in July 2015, Clinical Case Manager immediately updated current NSPs to state "Client will *continue* to receive ILP classes at the group home and LST as they are offered through agencies on the weekends."

The goals identified under "Identified Treatment Needs/Outcome Goals" details that modifications are needed on the 10/18/14 and 1/18/15 NSPs. The client met goals 1 and 2, and on the 4/18/15 NSP; and goals 1 and 2 were re-listed with no explanation as to why.

The client identified in the review vacillates in the program, with regular shifts in his participation in treatment and correlated progress (or lack thereof) in achieving treatment goals. Client appeared to have met goals 1 and 2 when the NSP stated so; however, he subsequently regressed and began to exhibit the same behaviors, thus requiring the same goal. Therapist will clarify on future NSPs reason the goal has been re-instated to ensure the reason the goal remains the same is clear.

An NSP for July was not signed by the child, group home, or CSW.

The 7/18/2014 NSP was signed by all necessary parties on 6/26/2014 and 6/30/2014; the signed NSP copy was not placed in the DCFS file, but correct copy was located in his DMH file. GH Clinical Case Manager and Therapist are responsible for copying and placing signed copies of NSP in client's residential file. Quarterly file audits will be conducted by Residential Manager for proper quality assurance of DCFS file management. This practice began August 27, 2015.

VI. PSYCHOTROPIC MEDICATION

#34) Are there current court-approved authorizations for the administration of psychotropic medication or did the GH document effort to obtain?

Beginning immediately, the RTC nurse/psych tech (or designee) will attempt to acquire current court approvals for all clients upon intake and/or in a timely manner (within 24 hours). If unable to acquire the required court approvals within the allotted time frame, the RTC nurse/psych tech (or designee) will call and email client's CSW and SCSW. If more than 5 attempts are made to contact CSW and/or SCSW without success, the RTC nurse/psych tech (or designee) will follow-up with written documentation higher up the county chain-of-command (i.e., supervisor's

manager) detailing RTC program requirements and attempts made to acquire required documentation. This procedure will assist in ensuring a successful outcome to securing the needed court approved psychotropic medication authorization from any CSW.

Thank you for your support to our program, and for your guidance to help our team to provide high quality care for the youth we serve. If any further information or details are needed regarding this corrective action, please contact us at (562) 977-6965.

Respectfully Submitted,

Xavier Floyd
Residential Manager