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DEPARTMENT OF CHILDREN AND FAMILY SERVICES

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December 7, 2015

To: Supervisor Michael D. Antonovich, Mayor
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Supervisor Sheila Kuehl
Supervisor Don Knabe

From: Philip L. Browning
Director

MARYVALE GROUP HOME FISCAL ASSESSMENT AND CONTRACT COMPLIANCE REVIEW

The Department of Children and Family Services (DCFS) Contract Administration Division (CAD) conducted a fiscal compliance assessment and contract compliance review of Maryvale Group Home (the Group Home) in August 2014. The Group Home has one site located in the Third Supervisorial District and provides services to the County of Los Angeles DCFS placed children and Probation placed youth, as well as children from other counties. According to the Group Home's program statement, its stated purpose is "to create a healthy, therapeutic milieu in which each individual child is able to grow physically, emotionally, educationally and spiritually."

The Group Home has a 72-bed site and is licensed to serve a capacity of 72 male and female children, ages 6 through 18. At the time of review, the Group Home served 41 DCFS placed children and 8 Probation placed youth. The placed children's overall average length of placement was 13 months and their average age was 15.

SUMMARY

CAD conducted a fiscal compliance assessment, which included an on-site 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 the Group Home 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 2 of 5 areas of the fiscal compliance assessment: Board of Directors and Business Influence; and Payroll and Personnel.

CAD identified deficiencies in the areas of: Financial Overview, related to a loss in operations; Loans Advances and Investments, related to non-FDIC insured investments; and Cash/Expenditures, related to an incomplete fixed assets inventory list.

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 respect and dignity.

The Group Home was in full compliance with 8 of 10 areas of our contract compliance review: Facility and Environment; 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.

CAD noted deficiencies in the areas of: Licensure/Contract Requirements, related to vehicles in which children are transported were not maintained in a good condition, Special Incident Reports (SIRs) were not submitted timely or cross-reported, comprehensive monetary and clothing allowance logs were not maintained, detailed sign-in/out logs were not maintained and Community Care Licensing (CCL) citations; and Maintenance of Required Documentation and Service Delivery, related to initial and updated Needs and Service Plans were not developed timely.

Attached are the details of our review.

REVIEW OF REPORT

On September 19, 2014, Linda Lai, DCFS CAD, held an Exit Conference with the Group Home's representatives: Steven Gunther, President and Executive Director; Ike Kerhulas, Vice President of Clinical Services; Albert Chin, Director of Residential Treatment Services; Gina Peck-Sobolewski, Director of Clinical Services; and Maelisa Hall, Quality Assurance Manager. DCFS staff included Molly Sun, CAD Fiscal, and Jui-Ling Ho, Out-of-Home Care Management Division. The Group Home's 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 monitoring Corrective Action Plan (CAP) and Fiscal Corrective Action Plan (FCAP).

A copy of this compliance report has been sent to the A-C and CCL.

CAD conducted a follow-up visit to the Group Home on March 19, 2015, to verify the implementation of the CAP and FCAP.

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

PLB:EMLTI:ll

Attachments

c: Sachi A. Hamai, Chief Executive Officer
John Naimo, Auditor-Controller
Jerry E. Powers, Chief Probation Officer
Public Information Office
Audit Committee
Sybil Brand Commission
Steven Gunther, Executive Director, Maryvale
Leonora Scott, Regional Manager, Community Care Licensing Division
Lajuannah Hills, Regional Manager, Community Care Licensing Division

MARYVALE
FISCAL COMPLIANCE ASSESSMENT REVIEW
FISCAL YEAR 2014 - 2015

SCOPE OF REVIEW

The fiscal compliance assessment included the review of Maryvale's (the Group Home) financial records, for the period of October 1, 2012 through August 31, 2014. Contracts Administration Division (CAD) reviewed the financial statements, bank statements, check register and personnel files to determine the Group Home's compliance with the terms, conditions and requirements of the Group Home contract, 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 Group Home was in full compliance with 2 of 5 areas of the fiscal assessment: Board of Directors and Business Influence; and Payroll and Personnel.

Fiscal Compliance

CAD found the following areas out of compliance:

Financial Overview

During the review, the Group Home's Audited Financial Statements for its fiscal year ending September 30, 2013 indicated an operational loss of $1,408,211. The loss was due to non-subsidized accumulated imputed interest expenses and depreciation expenses. The Group Home's parent company has set aside funds to fulfill the interest obligation when it becomes due in 2016. The parent company pays for all unfunded capital expenditures.

Recommendation:

The Group Home management shall ensure that:

1. It develops and implements an operational plan to eliminate the net asset deficit and to operate the Group Home without incurring annual losses.

Loans, Advances and Investments

The Group Home has investments in non-Federal Deposit Insurance Corporation (FDIC) insured accounts that include corporate stocks and bonds, money market funds and certificates of deposit, government securities, pooled investment funds, mutual funds and real assets. The Group Home confirmed it does not invest Department of Children and Family Services (DCFS) funds.

Recommendation:

The Group Home management shall ensure that:

2. DCFS funds are not invested or held in non-FDIC insured accounts.

Cash/Expenditures

- The Group Home's inventory list of fixed assets did not include the serial number or the funding source.

Recommendation:

The Group Home management shall ensure that:

3. An inventory list of fixed assets is maintained that includes the serial number and funding source.

MOST RECENT FISCAL REVIEW CONDUCTED BY THE AUDITOR-CONTROLLER

The most recent fiscal review of the Group Home posted by the A-C was on May 5, 2010. The A-C review was for the Department of Mental Health (DMH) contracts for County Fiscal Years 2007-2008 and 2008-2009. This report identified $8,267 of costs that required reallocation and $333 in unallowable alcohol costs that were reallocated. The cost for the alcohol was for the Group Home's annual Board of Directors and Advisor Board meeting with the facility, food and beverages paid on one invoice that was inadvertently allocated to DMH programs. This was correctect by the Group Home.

NEXT FISCAL COMPLIANCE ASSESSMENT

The next fiscal compliance assessment of the Group Home will be conducted in County Fiscal Year 2015-2016.

MARYVALE GROUP HOME
CONTRACT COMPLIANCE MONITORING REVIEW SUMMARY

License # 191500468
Rate Classification Level: 12

	Contract Compliance Monitoring Review	**Findings: August 2014**
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. Improvement Needed
	8. Detailed Sign In/Sign-Out Logs for Placed Children	8. Improvement Needed
	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. Full Compliance
	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 Workers Monthly Contacts Documented	7. Full Compliance
	8. Children Assisted in Maintaining Important Relationships	8. Full Compliance
	9. Development of Timely, Comprehensive Initial NSPs with Child's Participation	9. Improvement Needed
	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 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	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 Extra-Curricular, Enrichment and Social Activities (GH, School, Community) 13. Children Given Opportunities to Participate in	Full Compliance (All)

	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's Involvement 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	Full Compliance (All)

MARYVALE GROUP HOME
CONTRACT COMPLIANCE REVIEW
FISCAL YEAR 2014-2015

SCOPE OF REVIEW

The following report is based on a "point in time" monitoring visit. This compliance report addresses findings noted during the August 2014 review. The purpose of this review was to assess Maryvale 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 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, five Department of Children and Family Services (DCFS) placed children and two Probation placed youth were selected for the sample. 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, five sampled children were prescribed psychotropic medication. Their 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 provided.

CONTRACTUAL COMPLIANCE

CAD found the following areas out of compliance.

Licensure/Contract Requirements

- Vehicles were not maintained in good repair.

Although maintenance records showed that the Group Home's eight vehicles used to transport the youth was serviced regularly, a deficiency was identified on two of the vehicles. Van number one's window motor was broken and van number two's rear left turn light cover was broken. The Group Home immediately addressed the noted deficiencies. On August 28, 2014, CAD verified that the repairs had been completed.

- Special Incident Reports (SIRs) were not timely and cross-reported.

Although Special Incident Reports (SIRs) were properly documented; two were not submitted timely. An incident on July 21, 2014 was not reported until July 22, 2014, concerning a runaway minor. A second incident on May 27, 2014 was not reported until June 2, 2014. This incident was related to a minor reporting abuse that had taken place in the past. In addition, a third incident was not coded properly, as the SIR for a child's hospitalization was noted as an illness. On March 19, 2015, CAD confirmed that the Group Home implemented new procedures and trained all staff in November 2014.

- Comprehensive Clothing Allowance Logs were not maintained.

Clothing allowance logs were not properly maintained. The Group Home kept all receipts of clothing purchases, as well as the running account balance by youth. One youth's files had three consecutive monthly clothing allowance logs that did not contain signatures from youth and staff. The Group Home implemented a new clothing allowance form in November 2014. On March 19, 2015 CAD confirmed that the new form is being used and the logs were being maintained.

- Detailed sign-in/out logs were not maintained.

The resident sign-in/out logs were not maintained with required information. The Group Home maintained three templates to document visitation, including one sign-in/out form that is kept in the children's files. However, none of these individual logs had complete visitation information to monitor the children's whereabouts such as, the visitor's name, relationship, signature, date, and time-in/out. On March 19, 2015, CAD confirmed the Group Home had implemented procedures and a new sign-in/out log as of November 2014.

- Community Care Licensing Division (CCL) cited the Group.

CCL cited the Group Home as a result of deficiencies and findings on July 7, 2014. According to the report dated July 7, 2015, a client was sexually abused by another client during an outing. CCL requested a Plan of Correction (POC) by July 21, 2014 to ensure the safety and supervision of clients during outings. The Group Home submitted a POC, which included not allowing female residents on outings with only male staff. It is now the Group Home's policy to allow only one client to use the bathroom at a time and the Group Home will make every effort to always have two staff on outings with one of the staff being female. The POC dated July 14, 2014 was cleared by CCL on the same date. This referral was investigated by a DCFS Emergency Response Children's Social Worker (CSW) and the allegations of Sexual Abuse, General Neglect and At-Risk Sibling Abuse were deemed unfounded.

The Group Home acknowledged there was a lack of supervision on the outing, but filed an appeal to CCL on July 14, 2014 contesting the allegation of sexual abuse. CCL denied that appeal on August 25, 2014. The Group Home appealed again on September 9, 2014. As of the writing of this report, the second appeal is currently pending CCL review.

Recommendations:

The Group Home's management shall ensure that:

1. All vehicles are maintained in good repair.

2. SIRs are submitted timely and cross reported in accordance with the SIR reporting guidelines.

3. Comprehensive clothing allowance logs are maintained.

4. A detailed sign-in/out log is maintained.

5. The Group Home is in compliance with Title 22 Regulations and free from CCL citations.

Maintenance of Required Documentation and Service Delivery

- The Group Home did not develop timely initial NSPs with the child's participation.

The initial Need and Services Plan (NSP) was not completed timely for one of seven reviewed. This NSP was due on December 26, 2013. Both staff and child did not sign until March 13, 2014.

- The Group Home did not develop timely updated NSPs with the child's participation.

Fifteen updated NSPs were reviewed and one was not completed timely. This NSP was due on February 27, 2014. Both staff and child signed on March 7, 2014.

During the Exit Conference, the Group Home's representatives stated the delay on both NSPs was caused by the same staff who had documented performance issues. That staff was subsequently terminated.

The Group Home added a new Case Management Office in September 2014. The office with three new case managers is responsible for completing NSPs, which are reviewed by the Director and Assistant Director of Residential Services for both timeliness and comprehensiveness. The Group Home also completed a NSP training that was conducted by Out-of-Home Care Management Division (OHCMD) on November 7, 2014.

Recommendations:

The Group Home's management shall ensure that:

6. Initial NSPs are developed timely and with the child's participation.

7. Updated NSPs are developed timely and with the child's participation.

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

The OHCMD's last compliance report, dated January 29, 2014, identified eight recommendations.

Results

Based on CAD's follow-up, the Group Home fully implemented two of the recommendations for which they were to ensure:

- The Group Home staff obtains, or documents efforts to timely obtain, the DCFS CSW's or DPO's authorization to implement the NSP.
- Monthly contacts with DCFS CSWs or DPOs are appropriately documented.

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

- All vehicles in which children are transported are maintained in good condition.
- SIRs are cross-reported to all required parties via the I-Track database, in a timely manner.
- Comprehensive clothing allowance logs and weekly personal monetary allowance logs are completed and include all required signatures.
- The resident sign-in/out logs are properly maintained and available for review.
- 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.

Recommendation:

The Group Home's management shall ensure that:

8. The outstanding recommendations from the 2013-2014 monitoring report dated January 29, 2014, which are noted in this report as Recommendations 1, 2, 3, 4, 6 and 7, are fully implemented.

At the Exit Conference, the Group Home representatives expressed their desire to continue to strive to remain in compliance with all Title 22 regulations and contract requirements. The Executive Director stated that the Group Home will implement procedures to strive towards greater compliance.

A follow-up visit was conducted on March 19, 2015 by CAD, and the Group Home implemented all recommendations. CAD will continue to assess implementation of the recommendations during our next monitoring review. OHCMD will provide ongoing technical assistance prior to the next review.

October 20, 2014

Ms. Molly Sun
Department of Children and Family Services
Msun2@dcfs.lacounty.gov

Dear Ms. Sun,

Maryvale has adopted the following corrective actions in response to your agency's findings, per the exit interview on September 19, 2014.

FCAT Section I – Financial Overview
Question 3

- According to Audited Financial Statements for the period ending September 30, 2013, the group home incurred a loss from operations of $1,408,211. The agency also incurred a loss of $32,006 as of June 30, 2014.

Maryvale's Response:
For the past 158 years, Maryvale has been blessed with the generous support of its parent company. Maryvale's 2012/13 deficit consists primarily of two items: 1) $631k imputed interest related to an interest-free loan from *The Daughters of Charity Foundation*. Funds have been set aside by our parent company to fulfill this obligation when it becomes due in 2016; 2) $885k annual depreciation expense which Maryvale's parent company chooses not to subsidize since they pay for all unfunded capital expenditures. Neither of these two items have an effect on Maryvale's cash flow.

FCAT Section II – Loans, Advances and Investments
Question 12

- The Agency has multiple investments that consist of corporate stocks and bonds, money market funds and certificate of deposits, government securities, pooled investment funds, mutual funds, and real assets.

Maryvale's Response:
Again, because of the generous support of its parent company, Maryvale provides enhanced program services which exceed DCFS's requirements. Funding received by DCFS does not cover these enriched services. Therefore, zero County program funds are invested.

FCAT Section IV – Cash Expenditures
Question 28

- The Listing of fixed asset did not include serial number and funding source.

Maryvale's Response:
Effective immediately, Maryvale will capture the funding source, which in most instances is its parent company, along with each fixed asset's unique serial number.

We thank you for the diligence of your auditing team and appreciate your dedication in assisting us in serving children and families.

Olga Diaz
Vice President of Finance

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maryvale

A ministry founded in 1856
by the Daughters of Charity

cc: Steve Gunter
President & Executive Director
Maryvale

MARYVALE CORRECTIVE PLAN (CAP)

The following deficiencies were noted in the Group Home Monitoring Review Field Exit Summary dated September 19, 2014.

NUMBER	DEFICIENCY IDENTIFIED	CORRECTIVE ACTION PLAN
1.	Deficiency was identified on two out of eight vehicles used to transport Group Home youths. The 1998 Dodge Caravan's (5X03720) window motor crank was broken. The 2011 Toyota Sienna van (6PU926) rear left turn light cover was broken.	The Group Home Monitor returned to Maryvale on 8-28-14 for a follow-up visit, and verified the repairs had been completed. The following proactive plan ensures that vehicles are in a safe operating condition. All vehicles on alternating months receive safety inspections. Inspections shall include, but are not limited to, drive train, brakes, windshield wipers, tire life, mechanical leaks and interior functions. These items are checked off on our inspection report and kept on file for each vehicle. In addition to this, vehicles are used with sign in and sign out sheets depicting vehicle assessments. Items include, but are not limited to, body damage, cleanliness, and gas levels etc. and are documented with each use and trip of vehicle.
2.	The seven selected case files shows Special Incident Reports have been submitted timely and cross-reported to all required parties; however, OHCMD quality assurance reviewer identified two Special Incident Reports for non-selected cases not reported timely, and one resident had an unreported hospitalization in June 2014.	A Preliminary plan for Special Incidents Reports will be implemented no later than **10/24/14.** 1) Special Incident Reports are currently in the process of being reviewed by an Administrative Improvement Committee. 2) Special Incident Reports will be strictly monitored by Administrative staff for comprehensiveness, accuracy and timeliness moving forward. Group Supervisors will be re-trained and held accountable for the daily process under the direct supervision of the Director of Milieu Services. Previous incidents will be analyzed and reported as indicated. 3) Associates will be re-trained on Policy and Procedures regarding Special Incident Reporting by **10/24/14.** A checks and balance system will be implemented that requires the Group Supervisors to first review all incident reports made within their unit. The Director of Milieu Services will complete a second review before items are formally reported by administrative staff.

NUMBER	DEFICIENCY IDENTIFIED	CORRECTIVE ACTION PLAN
3.	One resident file had three monthly clothing allowance logs (December 2013, January and February 2014) that did not obtain either resident or staff signature.	Effective immediately, all monthly clothing allowance logs will include either the signature of the resident or the staff. Since this finding, there have been no incidences where clothing allowance logs did not contain those signatures. A new Clothing Allowance Form will be introduced by Tuesday **10/21/14**. The form will be monitored by Group Supervisors and verified by the Director of Milieu Services for **ALL** signatures, accuracy and comprehensiveness. Accounting staff will process reimbursement in tandem with the Director of Milieu Services and the Group Supervisors.
4.	The Agency maintains three templates of visitation log: General, Cottage and Individual Visitation. However, staff did not utilize these logs properly to document detailed visitation information as designed. Many forms do not have complete information that should include visitor name, role/relationship, signature, date, and in-out times. Some visitation forms were not filed timely.	1) Visitation Forms/Procedure: a. Group supervisors will decide on universal sign in-out sheet at supervisor meeting on **10/21/14**. The form will serve as the official sign in/out sheet and will be monitored by Group Supervisors and verified by the Director of Milieu Services. b. Campus Support will verify identification of visitors at time of visit but not sign-in visitors in order to support use of just one sign-in sheet for purposes of clarity. c. Groups will walk up to lobby and sign-in/out all visitors. Groups will secure and track all sign-in sheets. d. Mobile sign-in/out sheets (sheet from above) will be used during off-grounds visit drop offs and pickups. e. Staff will be trained on how to properly complete the visitation forms. 2) Electronic system for completing visitation request forms will be piloted in **November 2014** in St. Christopher's group. This will create a more effective system which will ensure more consistent follow through.
5.	Community Care Licensing (CCL) completed an investigation report on July 7, 2014 citing the Agency for lack of supervision when a client was sexually abused by another client on an outing.	Maryvale is contesting the allegation that a client was sexually abused by another client. There was lack of supervision on the outing, however, no significant data to support that a client was abused while on the outing exists. This is still pending with CCL and when the outcome is delivered this will be forwarded to Kong Ng, Children's Services Administrator I, Out-of-Home Care Management Division.
6.	C.J.'s initial needs and service plan was due on 12-26-13. Resident and Group Home staff signed on 3-13-14.	The therapist responsible for completing the NSP on 12-26-13 was significantly behind in her paperwork. She was counseled concerning this deficiency and eventually terminated from employment. The termination of employment resulted because she could not complete her documentation in the required time frame. An additional staff member had to complete this NSP which was signed on 3-13-14. It is important to note that this staff was under a Performance Improvement Plan due to the lateness of her documentation.

NUMBER	DEFICIENCY IDENTIFIED	CORRECTIVE ACTION PLAN
		• Effective immediately, the newly developed Case Management Office is responsible for completing NSP's which are reviewed by the Director of Residential Services for both timeliness and comprehensiveness. • DCFS Analyst Kong NG is providing training to Maryvale on **11/7/14**. • QA department is reviewing charts to ensure compliance.
7.	A.B.'s first quarterly Needs and Services Plan was due on 2-27-14. Resident and Group Home staff signed on 3-7-14. Two residents did not have updated needs and service plans due to length of placement. Effective May 1, 2014, all Needs and Services Plans need to be completed by due date and to obtain all signatures within five calendar days.	The NSP's are now being completed by three Case Managers. These positions were added in order to improve the quality and timeliness of this document that is being submitted to DCFS. This is the main responsibility of the Case Managers. This new process was put into place on a permanent basis at the beginning of September. It should be noted that there was only one NSP which was submitted late due to the difficulty in getting the assigned county social worker signature. In addition to the documents being completed by the due date, all signatures will be obtained within 5 calendar days. If Maryvale is unable to obtain these signatures, the document will be sent to DCFS. In order to improve the quality and comprehensive of the NSP's, Kong Ng will conduct training at Maryvale on **November 7th from 1 – 2:30 p.m.** His training will focus on the quality of the NSP documents and how to write effective goals.

Respectfully submitted,

Ike Kerhulas, Ph.D.

Ike Kerhulas, Ph.D.
Vice President of Clinical Services

Dated: October 20, 2014