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September 26, 2014

To: Supervisor Don Knabe, Chairman
Supervisor Gloria Molina
Supervisor Mark Ridley-Thomas
Supervisor Zev Yaroslavsky
Supervisor Michael D. Antonovich

From: Philip L. Browning
Director

PENNACLE FOUNDATION, INC. 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 Pennacle Foundation, Inc. Group Home (the Group Home) in October 2013. The Group Home has two sites located in the Second Supervisorial District and provides services to County of Los Angeles DCFS foster children and youth. According to the Group Home's program statement, it's purpose is "to create an effective life support system specific for each of its residents."

The Group Home has two, 4-bed sites and is licensed to serve a capacity of eight girls and boys, ages 10 through 17. At the time of review, the Group Home served eight placed DCFS children. The placed children's overall average length of placement was 19 months, and their average age was 17.

SUMMARY

During OHCMD's review, the Group Home was in full compliance with 2 of 10 areas of our Contract compliance review: Education and Workforce Readiness and Discharged Children.

OHCMD noted deficiencies in the following areas: Licensure/Contract Requirements, related to facility vehicles in which children are transported were not being maintained, Special Incident Reports were not cross-reported to all required parties, the Sign-In/Out Log was not maintained and Community Care Licensing (CCL) cited the Group Home for deficiencies and findings noted during CCL investigations; Facility and Environment, related to multiple exterior and interior deficiencies and there was a lack of outdoor recreation equipment; Maintenance of Required Documentation and Service Delivery, related to the Group Home not being compliant with its license, as one youth was 18 years old and the Group Home was not approved to serve Non-Minor Dependents (AB 12), the Group Home did not obtain or document efforts to obtain CSW's authorization to implement the Needs and Services Plans (NSPs),

the Group Home did not document monthly contact with DCFS CSWs, one child stated he had no visits with anyone and Initial and Updated NSPs were not comprehensive, as they did not include all of the elements in accordance with the NSP template; Health and Medical Needs, related to one child that did not have a timely annual medical examination; Psychotropic Medication, related to a child not having a Psychotropic Medication Authorization for Benadryl that was prescribed for sleep; Personal Rights and Social/Emotional Well-Being, related to a child reporting that he did not feel safe because "staff put their hands on you for no reason." OHCMD reported the child's allegations to the Child Protection Hotline based on the issues and concerns shared by the child; Personal Needs/Survival and Economic Well-Being, related to a lack of documentation regarding children receiving their monthly clothing allowance and weekly minimum monetary allowance on one occasion; and Personnel Records, related to staff members' job applications not being complete, including work experience and verification of the staff members' work experience; therefore, it was difficult to ascertain if they were qualified for their positions, one staff member did not receive a timely initial health screening and another staff member was not certified in the Emergency Intervention Plan.

REVIEW OF REPORT

On April 28, 2014, the DCFS OHCMD Monitors Kristine Kropke-Gay and Adelina Arutyuyan held an Exit Conference with Group Home representatives, Carolyn Ruffin, Executive Director and DeJuan Fletcher, Assistant Administrator. The Group Home representatives agreed with some of 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. The Pennacle Board of Directors recently notified us that they are voluntarily terminating their contract with DCFS and we are making arrangements to move these children to other placement.

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

PLB:EM:KR
RDS:kkg

Attachments

c: William T Fujioka, Chief Executive Officer
John Naimo, Acting Auditor-Controller
Jerry E. Powers, Chief Probation Officer
Public Information Office
Audit Committee
Sybil Brand Commission
Greer Davis, President Board of Directors, Pennacle Foundation
Carolyn Ruffin, Executive Director, Pennacle Foundation
Lajuannah Hills, Regional Manager, Community Care Licensing

PENNACLE FOUNDATION, INC. GROUP HOME
CONTRACT COMPLIANCE MONITORING REVIEW SUMMARY

5643 Corning Avenue	3908 Halldale Avenue
Los Angeles, CA 90056	Los Angeles, CA 90062
License # 198202803	License # 198207847
Rate Classification Level: 12	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. Not Applicable
	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. Improvement Needed
	9. CCL Complaints on Safety/Plant Deficiencies	9. Improvement Needed
II	**Facility and Environment** (5 Elements)	
	1. Exterior Well Maintained	1. Improvement Needed
	2. Common Areas Well Maintained	2. Improvement Needed
	3. Children's Bedrooms Well Maintained	3. Improvement Needed
	4. Sufficient Recreational Equipment/Educational Resources	4. Improvement Needed
	5. Adequate Perishable and Non-Perishable Foods	5. Full Compliance
III	**Maintenance of Required Documentation and Service Delivery** (10 Elements)	
	1. Child Population Consistent with Capacity and Program Statement	1. Improvement Needed
	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 Workers Monthly Contacts Documented	7. Improvement Needed

	8. Children Assisted in Maintaining Important Relationships 9. Development of Timely, Comprehensive Initial NSPs with Child's Participation 10. Development of Timely, Comprehensive, Updated NSPs with Child's Participation	8. Improvement Needed 9. Improvement Needed 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	1. Full Compliance 2. Improvement Needed 3. Full Compliance 4. Full Compliance
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 Chores Reasonable	1. Full Compliance 2. Improvement Needed 3. Full Compliance 4. Full Compliance 5. Full Compliance 6. Full Compliance 7. Full Compliance 8. Full Compliance 9. Full Compliance

	10. Children Informed About Their Medication and Right to Refuse Medication	10. Full Compliance
	11. Children Free to Receive or Reject Voluntary Medical, Dental and Psychiatric Care	11. Full Compliance
	12. Children Given Opportunities to Plan Activities in Extra-Curricular, Enrichment and Social Activities (GH, School, Community)	12. Full Compliance
	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	1. Improvement Needed
	2. Adequate Quantity and Quality of Clothing Inventory	2. Full Compliance
	3. Children's Involvement in Selection of Their Clothing	3. Full Compliance
	4. Provision of Clean Towels and Adequate Ethnic Personal Care Items	4. Full Compliance
	5. Minimum Monetary Allowances	5. Improvement Needed
	6. Management of Allowance/Earnings	6. Full Compliance
	7. Encouragement and Assistance with Life Book/Photo Album	7. Full Compliance
IX	**Discharged Children** (3 Elements)	
	1. Children Discharged According to Permanency Plan	Full Compliance (ALL)
	2. Children Made Progress Toward NSP Goals	
	3. Attempts to Stabilize Children's Placement	
X	**Personnel Records** (7 Elements)	
	1. DOJ, FBI, and CACIs Submitted Timely	1. Improvement Needed
	2. Signed Criminal Background Statement Timely	2. Full Compliance
	3. Education/Experience Requirement	3. Improvement Needed
	4. Employee Health Screening/TB Clearances Timely	4. Improvement Needed
	5. Valid Driver's License	5. Full Compliance
	6. Signed Copies of Group Home Policies and Procedures	6. Full Compliance
	7. All Required Training	7. Improvement Needed

PENNACLE FOUNDATION, INC. 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 Pennacle Foundation 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, four Department of Children and Family Services (DCFS) placed children were selected for the sample. The 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, three placed children were prescribed psychotropic medication. OHCMD reviewed the children's case files to assess for timeliness of Psychotropic Medication Authorizations and to confirm the required documentation of psychiatric monitoring.

OHCMD reviewed three 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 eight areas out of compliance.

Licensure/Contract Requirements

- Both Group Home vehicles were not well maintained, as they did not receive regular vehicle maintenance.

The Group Home Executive Director stated that the "Daily Vehicle Inspection Checklist" that is completed by staff before they drive the vehicle will document any issues noted with the vehicle. Additionally, vehicles will now be maintained in accordance with each vehicle's owner's manual.

- Special Incident Reports (SIRs) for the sampled children were reviewed. The 26 reviewed SIRs revealed that all were timely; however, 8 SIRs (Halldale site) were not submitted to OHCMD and 2 (Corning site) incidents that had occurred, as noted in two children's updated NSPs, had not been submitted into ITrack System.

The Group Home Executive Director stated that the SIRs not being cross-reported to all required parties were due to a new employee's oversight. She stated that the Group Home was not aware that the other two incidents should have been submitted into ITrack. The Group Home Executive Director stated that the assigned Case Manager at each group home will now provide oversight to ensure all incidents are submitted into ITrack System and cross-reported to all required parties. During NSP training provided by OHCMD on May 22, 2014, there was a discussion of SIR report documentation and the Group Home Executive Director, Assistant Administrator and Case Manager were provided a copy of Exhibit A-VIII, Special Incident Reporting Guide for Group Homes.

- Halldale site did not have Sign In/Out Logs.

The Group Home Executive Director stated that staff failed to ensure the log was maintained. She stated the Case Manager at each Group Home will now review the log three times a week to ensure the log is maintained.

- CCL cited the Group Home, as a result of deficiencies and findings noted during complaint investigations and evaluations of the Halldale site. CCL substantiated the allegations of "Staff grabbed and pushed client" and "Clients need permission to enter kitchen" for an incident that occurred at the Halldale site on May 22, 2013. A referral alleging General Neglect was made to the Child Abuse Hotline to address the aforementioned incident. The three citations by CCL included: (1) Personal Rights when a child was refused entry into the kitchen while other placed children were filling out paperwork in the kitchen; (2) Emergency Intervention Prohibition, related to a manual restraint that should not have been used "for the convenience of personnel or as harassment or discipline;" (3) Two trained staff were not available to conduct physical restraint, as only one trained personnel conducted the restraint.

CCL requested a Plan of Correction (POC) to ensure children are treated with dignity in personal relationships with staff and other persons; the children have access to the kitchen; a plan is in place to ensure manual restraints are not used for the convenience of staff or as harassment or discipline; and a plan to ensure a minimum of two trained staff members are available to conduct a physical restraint.

CCL reported that as of September 4, 2014, the deficiencies have not been cleared. The Department of Children and Family Services (DCFS) Emergency Response Children's Social Worker (ER CSW) deemed the allegation of General Neglect for the May 22, 2013 incident to be substantiated. OHCMD requested a Corrective Action Plan (CAP), which included providing a copy of their internal investigation conducted related to this referral and to provide documentation

of staff training and disciplinary action(s); and that Administrator and or Assistant Administrator will ensure that ongoing training is provided for all staff on the children's Personal Rights.

In December 2013, CCL cited the Group Home for the allegation of "Staff emotionally abused client" for an incident that occurred at the Halldale site on October 31, 2013. The citation of Personal Rights was related to children not being treated with dignity in their personal relationships with staff and other persons. CCL requested a POC, which included a plan to ensure children's personal rights are not violated. CCL cleared the deficiency on December 16, 2013.

With regard to the October 31, 2013 incident, the DCFS ER CSW deemed the allegation of Emotional Abuse, Physical Abuse and General Neglect to be substantiated. OHCMD requested a CAP, which included a Safety Plan for the child, a copy of the internal investigation with regard to the allegation, a plan to prevent similar incidents from happening in the future, steps that will be taken to ensure all SIRs are thoroughly documented and cross-reported timely to all required parties, and identify the person responsible for implementing the CAP.

The Group Home Executive Director stated that the POC and CAP included staff training and one of the staff members no longer works for the agency and the other staff member is not working until he is able to clear the substantiated finding with DCFS.

Recommendations

The Group Home's management shall ensure that:

1. The vehicles in which children are transported are maintained.

2. SIRs are appropriately documented and cross-reported timely.

3. Sign In/Out Logs are maintained.

4. The Group Home sites are in compliance with Title 22 Regulations and free from CCL citations.

Facility and Environment

- A walk-through of the Corning site exterior and grounds determined that the front of the house had protruding wires.

The Facility Manager stated that the address plate had been re-located and will have the non-operational wires immediately removed. A backyard exterior vent lacked a screen, the crawl space was not covered, and the front of the house had an unsecured small door, which is an access space with electrical wires and the space has access into the living room. On April 29, 2014, OHCMD observed the above-mentioned repairs were completed.

- A walk-through of the Halldale site exterior and grounds determined that large portions of dry rot and/or unpainted wood in several areas of the exterior trim and eaves. Bedroom 1 and 2 had window screens with holes and bent frames. OHCMD was unable to inspect the garage

because it was locked and the Facility Manager stated that the landlord did not rent the garage to the Group Home. The Group Home Executive Director and Facility Manager were advised to obtain the key, as OHCMD must enter the garage.

On April 29, 2014, OHCMD observed the exterior trim and eaves had been repaired; however, Bedroom 1 had no screen on one of the windows. OHCMD was unable to view the inside of the garage, as the staff member did not have the garage key.

OHCMD found the following new findings: Bedroom 1 had a window that had been replaced and the exterior wood framing the window had not been painted. The water heater enclosure was bent leaving the water heater partially exposed. The staff stated the repairs would be completed and the garage key would be located to open the garage. On the fifth attempt to view the inside of the garage on May 8, 2014, OHCMD was able to see the garage, which contained maintenance supplies. Additionally, there was a screen on the bedroom window and the water heater enclosure had been repaired.

- A walk-through of the Halldale site common areas determined that the hallway had been patched and was not painted.

The Facility Manager stated that the patch would be painted.

- The bathroom had missing paint/exposed stucco between the sink and tub and the floor molding and wall to the right side of tub.

Above the tub/shower area was an exposed metal open pipe area, which could be used to conceal contraband.

The kitchen ceiling above the stove had a large hole that was duct taped.

The Facility Manager stated that the hole in the kitchen ceiling was where a stove vent had been located and that the ceiling would be repaired.

- The kitchen cabinet below the sink contained a gallon of bleach.

The Group Home Administrator immediately removed the bleach.

On April 29, 2014, OHCMD observed the above-mentioned repairs were completed, except for the bathroom floor area around the tub and toilet had not been repaired and appeared to be dirty and/or moldy. The duct-taped kitchen ceiling hole now contained a non-operational stove vent. The staff member stated that the vent's electrical installation was pending.

OHCMD found the following new findings: The kitchen cabinet below the sink contained a large bowl and beneath the bowl were wet spots. The staff member stated the wet cabinet was due to a plumbing leak that had been repaired. Further, OHCMD found the kitchen floor had several areas where the floor tile squares were popping up. The kitchen floor was also damaged, appearing to have been cut. OHCMD also observed that a door frame latch was loose and protruding which,

posed a safety hazard. Bedroom 3's hallway door entrance carpet was worn, as well as carpet snags in the living room in which people could trip.

On May 8, 2014, OHCMD inspected the floor around the tub and toilet area and found it to be free of dirt. The staff member stated that the landlord was going to replace the bathroom and kitchen flooring and carpet in the living room and hallway. OHCMD found that the kitchen cabinet below the sink was wet. The staff stated that maintenance staff will check for a leak below the kitchen sink plumbing.

- A walk-through of the Corning site children's bedrooms revealed that Bedroom 1 had an inoperable smoke detector.

The Group Home Executive Director stated that the smoke detector would immediately be replaced and provided documentation to show that a new smoke detector was installed.

- Bedroom 3 had all three windows that were painted shut and could not be opened.

  The Group Home Administrator stated that it would be immediately repaired and on April 29, 2013, OHCMD observed that the bedroom smoke detector and bedroom windows were operational.

- The Halldale site children's bedrooms had the following deficiencies: Bedroom 1 and Bedroom 2 had a bed obstructing the emergency exit window bar release lever.

The Group Home Administrator immediately re-arranged both beds to not obstruct the wall emergency exit window guard releases. The Group Home Administrator stated that he would advise all staff members that beds must remain as placed.

- The Bedroom 1 closet ceiling light bulb was broken with exposed filaments.

The Group Home Administrator immediately replaced the broken light bulb.

- Bedroom 1 had a dresser drawer with 2 broken drawers and 6 exposed nails.

The Facility Manager immediately removed the dresser to remediate the safety issue. The Group Home Executive Director stated that the dresser will be replaced.

- Bedroom 2 had an unpainted patched wall.

The Facility Manager stated that a child had written graffiti on the wall and the graffiti had been removed and the area will be re-painted.

On October 31, 2013, OHCMD met with the Group Home Executive Director, who stated that her staff had apprised and showed her the pictures of the physical plant deficiencies at the Halldale site. The Group Home Executive Director stated that she would contact the owner of the property to have the Halldale site repairs completed. The Group Home Executive Director stated that she

understands that the Halldale site "is not up to par" and is diligently working to make physical plant improvements to improve the functioning of the Halldale site.

On April 29, 2014, OHCMD observed Bedroom 1's closet light bulb remained intact and the broken dresser that had been previously removed had been replaced with an operational dresser. None of the beds were obstructing the emergency window guard exit levers and Bedroom 2's patched wall had been painted.

Following the Exit Conference, the Group Home Executive Director stated that they have a system in place to maintain the Group Homes. She stated that when a repair is needed, staff members are to complete a work order in the computer, which is e-mailed to multiple staff members. A repair list is maintained, with priority given to safety-related, urgent repairs. She stated that moving forward; the Facility Manager and Case Manager at each Group Home will oversee the maintenance at each Group Home.

- The Halldale site did not have any outdoor recreation equipment; however, on April 29, 2014, OHCMD observed next to the garage a newly-built, roomy recreation room with french doors. The recreation room contained a well-maintained pool table and equipment, as well as a weight machine and couch.

Recommendations

The Group Home's management shall ensure that:

5. Exterior and the grounds are well maintained.

6. Common areas are well maintained.

7. Children's bedrooms are well maintained.

8. Group Home obtains recreational equipment.

Maintenance of Required Documentation and Service Delivery

- The Group Home was not in compliance with the Group Home's program statement, as they are not AB 12 approved for Non-Minor Dependents and had an 18-year-old youth residing at the Halldale site.

The Group Home Executive Director stated that the child had been placed at the Group Home for many years. She stated that they had advised the CSW that the facility was not AB 12-approved and the Non-Minor Dependent would need to be replaced. The Group Home Executive Director stated that the agency has no future plans to provide placement for Non-Minor Dependents and in the future will not allow children to stay past their 18th birthday.

- The DCFS CSW authorization to implement the Needs and Services Plan (NSP) were not attempted or requested in a timely manner for 5 of 11 reviewed NSPs.

- For 2 of 4 children reviewed NSPs did not include monthly contacts with their DCFS CSW.

- One child stated that he had no contact with anyone.

The Group Home Executive Director stated that although the NSP did not document the child having contacts with anyone, he frequently AWOL'd to his grandmother's home. She stated that the Case Manager will ensure contact with significant others will be documented in future NSPs.

- For 3 of 4 sampled children's Initial NSPs reviewed, one child's Initial NSP had been previously reviewed. Although all three Initial NSPs were timely, the current NSP template was not being utilized, as well as none of the NSPs were comprehensive, as they did not include all of the elements in accordance with the NSP template. Specifically, one NSP did not have the child's date of birth, the child's date of admission was inconsistent with the Group Home roster, the Psychotropic Medication Authorization (PMA) date was blank, the ILP comment box was blank, and the permanency planning goal was not measurable. Another child's Initial NSP had an incorrect date of admission, was missing medical information and the permanency planning goal was not measurable. The other child's NSP school enrollment date was inconsistent with documentation in the NSP education comment section, as well as the one NSP goal was not a permanency planning goal. Also, the Signature Page documenting the person preparing the report was blank. Further, all three NSP Signature Pages did not document the date(s) the NSP was mailed/faxed/handed to DPO/CSW.

- Seven Updated NSPs were reviewed. The NSPs were all timely; however, none were comprehensive, as they did not include all the required elements in accordance with the NSP template. Specifically, they had the same aforementioned issues, in addition to some of the education and life skills sections were missing information and one child's permanency planning goal was not measurable. Another child's NSP had inconsistent mental health information. Some NSP visitation sections stated "N/A" without an explanation. One child's Updated NSP did not document the GH/CSW contact for one month. Another child's Updated NSPs had an incorrect birth date and school enrollment dates, as well as the permanency planning goal was not measurable and 1 Signature Page was blank for the person who prepared the NSP.

The Group Home Executive Director stated that representatives from Pennacle Foundation attended the NSP training provided by OHCMD in August 2013 and were made aware of the NSP requirements. The Group Home Executive Director stated they have now implemented the Group Home Case Manager as the oversight to ensure all NSPs are thoroughly documented, monthly contacts with CSWs are made, and are submitted timely for CSWs authorization to implement and modify NSPs. OHCMD provided a packet and NSP training at the Group Home's headquarters on May 22, 2014.

Recommendations

The Group Home's management shall ensure that:

9. Children are placed in accordance with the Group Home's population criteria.

10. Group Home obtains or document efforts to obtain the CSW's authorization to implement the NSPs.

11. Group Home document monthly contacts with CSWs.

12. Group Home assists children in maintaining important relationships.

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

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

Health and Medical Needs

- One child's file did not have documentation of receiving an annual physical examination, only doctor visits for headache and nausea.

The Group Home Executive Director stated the Case Manager and Facility Manager will ensure children receive an annual physical examination and that documentation is contained in the child's file.

Recommendation

The Group Home's management shall ensure that:

15. Children receive an annual physical examination, in accordance with CHDP guidelines.

Psychotropic Medication

- One child did not have a Psychotropic Medication Authorization for Benadryl, which was being prescribed for sleep.

The Group Home Executive Director stated they were not aware that Benadryl prescribed for sleep required a Psychotropic Medication Authorization and has now advised the staff that one is required. She stated that the Group Home's Case Manager will now ensure all placed children prescribed Benadryl for sleep will have a Psychotropic Medication Authorization and receive medication management on a monthly basis.

Recommendation

The Group Home's management shall ensure that:

16. Children have a current Court-approved Psychotropic Medication Authorization.

Personal Rights and Social/Emotional Well-Being

- One youth stated that he did not feel safe in the Group Home because "staff put their hands on you for no reason." Upon further inquiry by OHCMD, the youth alleged that a staff member blocked him from leaving the kitchen when he tried to walk past the staff. The youth

stated that he told the staff member to "shut up" and jumped over the kitchen counter into the living room. He alleged that the staff member then pinned him to the wall. The child denied being hurt or currently feeling unsafe in the Group Home.

OHCMD immediately contacted the Child Protection Hotline (CPHL) to generate a referral. Subsequently, the DCFS ERCSW deemed the allegation of Physical Abuse to be Inconclusive. DCFS Out-of-Home Care Investigations Section requested a CAP, which included a plan to assess the Group Home staff as to their training, education, experience and whether they are appropriate to work with RCL level 12 children, as well as to provide a plan ensuring that all Group Home staff adheres to SIR reporting and how the Group Home will monitor timely submission of SIRs and provide a safety plan ensuring that children placed at the Group Home are safe and free from abuse.

The Group Home Executive Director stated that the staff members received training to ensure children's personal rights are not violated.

Recommendation

The Group Home's management shall ensure that:

17. Children feel safe in the Group Home.

Personal Needs/Survival and Economic Well-Being

- Three of the reviewed children that have been subsequently discharged did not have documentation that their clothing allowance balance had been spent and/or that their CSW received their unspent clothing allowance upon their discharge. The Group Home had documentation that one of the children had a clothing allowance balance of $540.84 in the same month that he was discharged.

Although OHCMD requested documentation of the three children's spending clothing allowance and/or documentation that their CSWs received their unspent clothing allowance balance, the Group Home was unable to provide the documentation. Therefore, OHCMD was unable to ascertain if the children received their monthly clothing allowance.

The Group Home Executive Director stated that they were unable to locate the two files that were archived when the agency elected to temporarily close one of the Group Homes. Furthermore, OHCMD was advised that the third child at the other Group Home had spent her clothing allowance before she was discharged. However, OHCMD was not provided the documentation; therefore, was unable to verify that the children received their clothing allowance.

- One child's monetary log documented that on one occasion she received $5, rather than the minimum weekly monetary allowance of $7.

The Executive Director stated that the staff member made an error in documentation and that all children receive at least the minimum weekly monetary allowance.

Recommendations

The Group Home's management shall ensure that:

18. Children are provided at least $50 per month of clothing allowance that it is documented in their log.

19. Children are provided with the minimum monetary allowance and that it is correctly documented in the log.

Personnel Records

- OHCMD reviewed three staff members' personnel records. One was unclear related to the date the staff member received criminal clearance to work in the Group Home. The form used by the Group Home to document the criminal clearance was incomplete.

Although OHCMD requested for the agency to provide documentation from CCL of the staff member's criminal clearance dates, the Group Home was unable to provide the information. Furthermore, OHCMD contacted CCL and verified that the employee was associated to the Group Home 13 days after his hire date.

The Group Home Executive Director stated the employee was not working at the Group Home when he was hired. She stated they now have a designated staff member to ensure newly-hired staff member's documents are complete prior to being hired.

- For 2 of 3 staff members' personnel records reviewed had incomplete job applications. Further, the agency was unable to provide documentation of job employment verification for the three reviewed staff. Additionally, the staff member's job description did not clearly state the job requirement/qualifications; therefore, OHCMD was unable to determine if the staff members were qualified for their positions when they were initially hired.

The Group Home Executive Director stated that after OHCMD brought this issue to their attention, all of the current staff member's files have been audited to ensure job applications are complete. OHCMD requested the agency submit a request to amend their program statement to clearly state the qualifications/requirements for child care staff members. Receipt of the amended program statement by OCHMD is still pending as of September 4, 2014.

- One staff member did not receive a timely health screening. His health screening was 18 days late.

The Group Home Executive Director stated the employee was not working at the Group Home when he was hired. She stated they now have a designated staff member to ensure newly-hired staff member's documents are complete prior to being hired.

- One staff member did not have an Emergency Intervention Plan (EIP) certificate.

The Group Home Executive Director stated that the staff member will not work alone with children, including transporting children, without a Crises Prevention Institute (CPI)-certified staff member present until the staff member is certified in the agency's EIP of CPI. The Group Home Executive Director stated that the Administrator will ensure all employees are certified in their Emergency Intervention Plan.

Recommendations

The Group Home's management shall ensure that:

20. All employee personnel records contain clear documentation of the employee's criminal clearance dates and associated dates prior to their hire date.

21. All potential employees have completed job applications, verified work experience, as well as clearly-stated educations/experience requirements for child care workers.

22. All employees receive an initial timely health screening/TB clearance.

23. All employees receive all required training, including certification in the EIP.

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

The OHCMD's last compliance report, dated July 24, 2013, identified 15 recommendations.

Results

Based on our follow-up, the Group Home fully implemented 6 of 15 recommendations for which they were to ensure that:

- Disaster Drills are conducted and properly documented every six months.
- All children are progressing toward meeting NSP case goals and children's progress is documented.
- Children are enrolled in school within three school days of placement and all efforts to enroll children in their educational needs and goal are being addressed.
- Children's educational needs and goals are being addressed.
- The necessary services, such as tutoring, are provided to assist the children in increasing their academic performance.
- Children prescribed psychotropic medication have a current psychiatric evaluations/review.

The Group Home did not fully implement 9 recommendations for which they were to ensure that:

- Vehicles in which the children are transported are maintained.
- The Group Home is in compliance with Title 22 Regulations, including children's personal rights.
- The exterior and the grounds of the Group Homes are well-maintained.
- All children's bedrooms are well-maintained.

- The Group Home obtains or document efforts to obtain the DCFS CSW's authorization to implement the NSPs.
- DCFS CSWs are contacted monthly and is appropriately documented by the Group Home.
- 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.
- Children have Court-approved authorization for the administration of psychotropic medication.

Recommendation

The Group Home's management shall ensure that:

24. The outstanding recommendations from the July 24, 2013 report from the prior fiscal year monitoring review, which are noted in this report as Recommendations 1, 4, 5, 7, 10, 11, 12, 13 and 16, are fully implemented.

The Group Home Executive Director stated that the Group Homes will now adhere to regular maintenance of the vehicles, in accordance with the vehicle owner's manual; have implemented the use of a Sign-In/Out Log at the Halldale site; have trained staff members, in accordance with CCL's POC and DCFS' CAP to ensure children feel safe in the Group Home and their personal rights are upheld; the Case Manager and Facility Managers will now oversee the Group Home's maintenance; will transition children from the Group Home before their 18th birthday; and the Group Home's Case Managers will ensure comprehensive NSPs, including documentation of monthly contacts with CSWs and documentation to obtain CSWs authorization to implement NSPs.

The Group Home Executive Director stated that she understands that a child's "sick visit" will not supplant a child's annual physical examination and stated that she understands that children prescribed over-the-counter medication used for a psychotropic purpose must have Court approval and will have closer oversight to ensure employees are qualified and trained for their positions. OHCMD will verify that these recommendations have been implemented and provide technical assistance during our next visit to the Group Home in October 2014.

It should be noted that OHCMD conducted two informal meetings with the Group Home Executive Director and administrative team to discuss four Child Protection Hotline Referrals. On October 29, 2013, OHCMD met with the Group Home Executive Director and administrative team to discuss a referral that alleged General Neglect by a staff member that was deemed Inconclusive by DCFS.

On February 25, 2014, OHCMD conducted an informal meeting with the Group Home's Executive Director and administrative team to discuss three referrals that alleged Emotional Abuse, General Neglect, and Physical Abuse by staff members that were deemed Substantiated by DCFS, and the third referral alleged Physical Abuse by a staff member that was deemed Inconclusive by DCFS.

Further, on July 15, 2014, Pennacle Foundation Executive Director informed OHCMD that the property owner of the Corning site had sold the home and the girls would be moving to the

Halldale site. On July 22, 2014, OHCMD conducted an inspection at the Halldale site to ensure the Group Home met sufficient standards before the girls moved into the location. However, additional physical plant deficiencies were noted.

On July 29, 2014, OHCMD conducted a follow-up physical plant inspection and observed that all of the above deficiencies were repaired, with the exception of Bedroom 1, which had a crack in the ceiling and the front window panel paint was chipped. Additionally, the bathroom shower nozzle needed repair.

On July 30, 2014, OHCMD spoke with the Group Home Executive Director and informed her that the above-mentioned physical plant deficiencies were remediated, except for Bedroom 1; the front window panel; and the shower nozzle, which were not safety concerns, which resulted in the Halldale site being approved for the placement of the girls. Furthermore, OHCMD advised the Executive Director that OHCMD had made numerous visits to Halldale site due to multiple physical plant deficiencies, and although the Halldale site was now operational, should the Group Home continue to have physical plant deficiencies and fail to comply with the County contract provision and Title 22 Regulations, the Group Home is at risk of a "Hold" being imposed on the Group Home. The Group Home Executive Director acknowledged that she understood OHCMD's concerns.

MOST RECENT FISCAL REVIEW CONDUCTED BY THE AUDITOR-CONTROLLER

The Auditor-Controller conducted a fiscal review of the Group Home for the period of January 1 through December 31, 2011. The fiscal report, dated July 11, 2013 identified $37,245 in unallowable relocation fees, penalties, fines, and interest expenditures, and $1,639 in unsupported/inadequately supported credit card charges, employee payments and an overpayment to a consultant, for a total of $38,884. The DCFS Fiscal Monitoring and Special Payments Section informed OHCMD on October 23, 2013 that this amount had been paid in full.

#5-OK

Pennacle Foundation, Inc.

Changing our world one hug at a time

May 27, 2014

Kristine Kropke-Gay Group Home Monitor
Out of Home Care Management Division
9320 Telstar Ave. Suite # 2 16
El Monte, CA 91731

Dear Ms. Kropke-Gay

The following is the written Corrective Action Plan for Pennacle Foundation' overall program as it relates to the Group Home Monitoring Review Field Exit Summary conducted on 4/28/14.

1. (Section#1) Licensure/Contract Requirements:

SECTION CITED
(#3) -Does the group home maintain vehicle(s) in which the children are transported in good repair? (SAFETY)
(#4)-Are all special incident reports (SIRS) appropriately documented and cross-reported timely (SAFETY)
(#8) -Does the facility maintain a detailed sign in/out log for placed children? (SAFETY)
(#9) -Is the group home free of any substantiated Community Care Licensing complaints on safety and/or physical plan deficiencies since the last review? (SAFETY)

Implemented Immediately, current status:

#3)
Effective immediately, and ongoing, all vehicles used to transport clients shall be maintained in safe/ good, clean operating condition.
Effective immediately, and ongoing, all vehicles used to transport clients are placed on a weekly routine cleaning maintenance schedule, ensuring that all vehicles are kept clean and sanitary.
Effective immediately, transporting staff will conduct a visual vehicle inspection, and complete the provided inspection report prior to completing each route. (See Attachment)
Staff will immediately report any/all vehicle deficiencies lo administration for expedited repairs. Administration will ensure all vehicles requiring repairs are removed from the routes, and repairs are conducted in a timely manner. All repairs will be completed prior to the vehicle(s) being placed back in route rotation.

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Administration will facilitate and insure that all vehicles receive routine (quarterly) maintenance checks according to the vehicle owner manual, which will include but not be limited to oil changes, and fluid checks. Supporting documentation reflecting maintenance and repairs will be maintained and filed at Pennacle's administration office.

#4)
All personnel responsible for submitting SIRs have been notified of the person (s) who need to be appropriately cross-referenced when submitting all SIR via i-track, phone or fax.

#8)
Effective immediately and ongoing, Pennacle staff shall adhere to and maintain a detailed sign- in/sign-out log/or residents who leave the facility for any reason other than, school, or group home activities of Pennacle Foundation (according to DCFS SOW). The log shall include the name of the child, his/her destination, the time he/she left the facility, the anticipated time of return, and the name and telephone number of the person who is responsible to supervise the resident while he/she is away from the facility. (See Attachment)

#9)
During this reporting period it was confirmed that there were two substantiated CCL reports, a CAP and POC was submitted to each respective agency. The Agency will continue to monitor/ train and implement oversight in monitoring program deliveries with all residents, ensuring the resident's environment, safety and well-being at all time.

Plan To Prevent Reoccurrence:

#3)
On 11/30/13, all staff received ongoing refresher/training on Vehicle Inspection(s) and Maintenance procedures. All staff is required to submit their vehicle inspection reports to administration each Friday of each week. Each vehicle will be/is placed on a weekly routine cleaning maintenance schedule, which includes but not limited to; being washed and vacuumed. Vehicles requiring repairs will be immediately removed from the transportation routes, at which time staff will notify administration of the needed repairs immediately. Administration will ensure that all repairs are completed in a timely manner, and returned to their route(s) once all repairs are completed. Administration will facilitate and insure that all vehicles receive routine (quarterly) maintenance checks, which will include but not be limited to oil changes, and fluid checks. Supporting documentation reflecting maintenance and repairs will be maintained and filed at Pennacle's administration office.

#4)
Plan To Prevent Reoccurrence: program director for each program will now within 24 check and submitted SIR to ensure completeness and adherence to the proper submission of the agencies special incident reports.

#8)
The CONTRACTOR shall maintain a detailed sign-in/sign-out log for Placed Children who leave the facility for any reason other than regular school days, or group home activities of the CONTRACTOR. This log shall include the name of the child, his/her destination, the time he/she left the facility, the anticipated time of return, and the name and telephone number of the person who is responsible to supervise the resident while he/she is away from the facility.

#9)
The Agency will continue to monitor/ train and implement oversight in monitoring program deliveries with all residents, ensuring the resident's environment safety and well-being at all time.

Person Responsible for Implementing Plan of Correction:
GH-Staff/ GH- Facility Managers and Administration

Person Responsible for Monitoring to Ensure Corrective Action Remains Implemented and is Working as Intended:
Administration and Program Director

2. (Section #2) Facility and Environment

SECTION CITED
(# 10) -Are the exterior and the grounds of the group home well maintained (Front and back yards clean, and adequately landscaped condition of home exterior, driveway, walkway and fences; window screens)? (SAFETY)
(#11) -Are common quarters well maintained? (Clean/sanitary; neat; adequate furniture and lighting; home-like environment, no safety hazards) (SAFETY)
(# 12) -Are children's bedrooms well maintained? (Clean/sanitary; neat; comfortable; adequate lighting, window coverings, and storage space; beds, mattresses, furniture, flooring; full complement of linens on beds, age -appropriate decorations; and appropriate sleeping arrangements) (SAFETY) (#13) -Does the group home maintain sufficient recreational equipment and an appropriate selection (quality and quantity) reading materials and educational resources and supplies, including computers, which are age-appropriate, readily available to children, and in good repair? (SELF-SUFFICIENCY)

Implemented Immediately

#10)
Effective immediately, and ongoing, staff will conduct routine grounds checks (utilizing the Facility Check List; see attachment), prior to the beginning of each shift, ensuring that the facility exterior and interior grounds are well maintained, and free of any hazards at all times. . The GH- Facility Manager will monitor the facilitation and completion of the Facility grounds Check List responsibilities weekly, ensuring all staff is following the Safety procedure.
All repairs and landscape needs/ request will be documented on the Repair Request form (See attachment) and is/will be immediately forwarded via fax to administration. Repairs and landscape needs will be immediately addressed by Pennacle's Maintenance Department.

Upon completion of the repairs, the Maintenance department will document the completion of the repairs on the said Repair Request form, which will be stored at the administration office.

Effective immediately, and ongoing, the maintenance department will schedule routine grooming of the facility grounds/landscape, ensuring that the grounds are maintained and free of debris and all hazardous materials at all times.

#11)
Effective immediately, and ongoing, Pennacle staff/facility manager will conduct routine facility checks, prior to the beginning of each shift, to ensure that all window coverings, storage space, beds, mattresses, furniture, flooring, full complement of linens on beds, fixtures, and that the facility exterior and interior grounds are well maintained and free of any hazards, providing residents with comfort at all times.

#12)
Effective immediately, and ongoing, Pennacle staff/facility manager will conduct routine grounds checks, prior to the beginning of each shift, to ensure that all window coverings, storage space, beds, mattresses, furniture, flooring, full complement of linens on beds ,fixtures, and that the facility exterior and interior grounds are well maintained and free of any hazards, providing residents with comfort at all times.

#13)
At the time of inspection it was noted that there were recreational equipment in the facilities inspected however it was determined that the outside equipment was not complete i.e. a net and no ball. The facility did show that the set was complete in a subsequent visit. The facility manger and Administration will ensure that all recreational equipment is maintained incomplete set and replaced immediately ifnot.

Plan To Prevent Reoccurrence:

#10)
All staff will receive ongoing/refresher training regarding resident's safety, and ongoing upkeep and maintenance of the facility grounds. Staff will conduct routine grounds checks; using the Facility Check List form, prior to the beginning of each shift. The GB-Facility Manager will monitor and review the Facility Grounds Check list weekly, ensuring that all staff are following the implemented procedure, and the facility grounds are well maintained and free of all hazards at all times.
#11)
All staff will receive ongoing/refresher training regarding resident's safety, and ongoing upkeep and maintenance of the facility grounds. Staff will conduct routine grounds checks; using the Facility Check List form, prior to the beginning of each shift. The GB-Facility Manager will monitor and review the Facility Grounds Check list weekly, ensuring that all staff are following the implemented procedure, and the facility grounds are well maintained and free of all hazards at all times.

#12)
The GH- Facility Manager will monitor the facilitation and completion of the Facility grounds Check List responsibilities weekly, ensuring all staff is following the Safety procedure. All needed repairs of furniture and or fixtures will be reported (via fax of a Repair Request form), and repaired/rep/aced immediately, ensuring that the facility exterior and interior grounds are continuously well maintained and in good working condition.

#13)
The GH- Facility Manager will monitor the recreation equipment and by physically checking and reporting in their shift reports that the equipment is wellmaintained in full set and good order. Replacement will be immediate if any recreational equipment falls short of excellent maintenance.

Person Responsible for Implementing Plan of Correction:
OH -Facility Manager, Staff, and Administration

Person Responsible for Monitoring to Ensure Corrective Action Remains Implemented and is Working as Intended:
Administration and Program Director

3.(Section #3) Maintenance Of Required Documentation And Service Delivery

SECTION CITED
(#15)-Are children placed in accordance with the group home's capacity and population criteria? (WELL-BEING)
(# 16)-Did the group home obtain or document efforts to obtain County worker's authorization to implement the Needs and Service Plan? (WELL BEING)
(#21) -Are County Workers contacted monthly by the GH and are the contacts appropriately documented in the case file? (WELL-BEING)
(#22) -Does the agency assist the children in maintaining important relationships? (PERMANENCY)
(#23)-Did the treatment team develop timely, comprehensive, Initial Needs and Service Plans with the participation of the developmentally age-appropriate child? (WELL BEING)
(#24) -Did the treatment team develop timely, comprehensive, updated Needs and Service Plans with the participation of the developmentally age-appropriate child? (WELL BEING)

Implemented Immediately

#15)
All intake will continue to be reviewed for appropriate placement by the Child and Family team (CFT), Additionally a case manager is now assigned to each home to work with the Administrator to ensure that all appropriate documentation, interview eel. are obtained in order to make a sound comprehensive effective decision.

#16)
Effective immediately, and ongoing, Pennacle administration will ensure that all CSW authorizations are obtained to implement all NSP's. If a signature/authorization is

unattainable, supporting documentation of all efforts and attempts made towards obtaining the authorization will be attached to, and or documented on the addendum page of said NSP before the NSP is filed in the clients' file.

#21)
Effective immediately and ongoing, Pennacle staff will communicate and document their contacts on the (previously implemented) CSW Contact form (see attachment), on a monthly basis. Staff will continue to forward all CSW contact information to administration monthly via the provided form. Administration will then ensure that dates of the agencies contact with all CSW's will be thoroughly transferred into all NSP's.

#22) The treatment team, administration, and GH staff will ensure that all minors placed have clearly identified outside positive relationships and that the specific relationships are instrumental in the youth lives. The treatment team, administration, and GH staff will ensure that visits and all activities are appropriately documented in each child's NSP and quarterly reports.

#23& 24)
Effective immediately, and ongoing, the treatment team(CFT) in collaboration with the County Worker, GH staff, and age- appropriate child, will develop outcome based, specific, measurable, ·attainable and a overall more comprehensive Initial and updated NSP by taking additional session time with each minor placed, within their initial 30 days of placement and an updated NSP each 90 days thereafter.

The treatment team, administration, and GH staff in collaboration with the County worker, will ensure that all minors placed have clearly identified permanency goals, and that progress on medical appointments/follow-up appointments, school, and family contact and or visit information is appropriately documented in each child's NSP.

Plan To Prevent Reoccurrence:
The Facility Manager will routinely collect and forward all documentation reflecting the staff's daily efforts to make contact with all outside agencies, and Needs and Service Plan goals progress in the areas including but not limited to; school enrollment, medical appointment and follow-ups, permanency, family visitation, and contact for each minor placed.

Administration will ensure that all supporting documentation is collected from the GH staff; reflecting authorizations to implement NSP 's, goal progress, visitation, education progress, medical updates and all other collected information is accurately documented in each minor's NSP.

Person Responsible for Implementing Plan of Correction:
Facility Managers, Administration, and Treatment Team

Person Responsible for Monitoring to Ensure Corrective Action Remains Implemented and is Working as Intended:
Administrator and Facility Manager, Program Director

4. (Section #5) -Health and Medical Needs

SECTION CITED
#31) -Are required follow-up medical examinations conducted timely? (WELL-BEING)

Implemented Immediately
#31)

The Facility Case Manager will ensure that all medical and dental examinations are completed in a timely manner. This will be done by creating a master calendar and reports being submitted to the administrator in regards to meeting

Plan To Prevent Reoccurrence:
#31)
The facility Case Manager will ensure that all medical and dental examinations are completed in a timely manner.

Person Responsible for Implementing Plan of Correction:
Facility Case Manager

Person Responsible for Monitoring to Ensure Corrective Action Remains Implemented and is Working as Intended:
Administrator

5.(Section #6)-Psychotropic Medication

SECTION CITED
#34) -Are there current court- approved authorizations for the administration of psychotropic medication or did the OH document efforts to obtain? (WELL BEING)

Implemented Immediately
#34)

Effective immediately, and ongoing, administration will continue to work with the treatment team, ensuring that all psychotropic medication specifically OTC medication that is used in a psychotropic manner that authorizations are submitted, followed-up, received, and filed in a timely manner. Facility managers and administration will ensure that upon completion of intake, all residents prescribed psychotropic medication will be received with a current psychotropic authorization/DCFS 179 form; authorizing staff to administer all prescribed psychotropic medications. A copy of all current psychotropic authorizations/DCFS 179forms will be maintained in the residents facility file and at the administrative offices.

Plan To Prevent Reoccurrence:
Administration and facility managers will review residents files monthly, ensuring that all psychotropic authorizations/DCFS 179 forms, and mental health progress notes are current at all times. Copies of psychotropic authorizations/DCFS 179 forms, evaluations, and progress/review notes will be maintained in the residents facility file and at the administrative offices.

Person Responsible for Implementing Plan of Correction:
Facility Managers and Administrator

DAILY FACILITY GROUND/SHIFT CHECK LIST

DAILY TASK	SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	COMMENTS
DATE								
check facility for cleanliness								
check food quantitiy/quality								
check for current program license								
check for current resident roster								
check for current staff roster								
check fridge for proper food storage								
check grounds for contraband								
check vehicle for ample gas/milage								
check vehicle for damage repairs								
Faciity walk thru/ beginning of shift								
Note repairs/maintanence needs								
Review communication log/reports								
Review consequences								
Check med book/box for accuracies/sig.								
Review medical calender								
Review menues for snacks/meals								
Review points and levels								
Review S.I.R's								
check hygiene boxes/supples/clean								
(wed)Pull trash cans to curb								
Residents dresser drawers								
Residents closets								
residents laundry								
complete shift reports/shift documents								
conduct group								
issued clothing allowance								
issued hygiene supplies								
issued weekly allowance								
smoke detector check								
fire exstinguisher checked								
conduct fire drill								

STAFF SIGNATURE _____

Vehicle service request/ Accident report

Date_____

Facility_____

Staff making request: _____

Description of issue

_____

_____

_____

Date received:_____

Date completed:_____

By whom:_____

ACCIDENT REPORT

_____

_____

_____

_____

_____

_____

_____

_____

Resident's Home Pass Sign Out Sheet

Date	Name of Resident	Responsible Party , Address and Phone Number	Time out	Expected time and date of return	Medication givin to responsible party	Staff on duty

REPAIR/SERVICE REQUEST

Date:

Repairs needed:

_____

_____

_____

_____

_____

_____

_____

_____

Date of Service/Repair started _____

Date Service/Repair completed: _____

Submitted by: _____

DAILY VEHICLE INSPECTION CHECKLIST

DATE _____

DRIVER _____

Prior to operation the driver is responsible to inspect each vehicle daily to confirm that it is in safe condition, that it is equipped as specified by the law and that all mechanisms are in good working order.

The inspection includes but not limited to the following:

ITEMS TO CHECK	STATUS
1. All gauges, indicators and warning devices.	
2. Horn	
3. Drivers and passenger seat belts	
4. All doors, emergency releases and windows	
5. All seats, handrails and modesty panels	
6. Interior and exterior lighting systems	
7. All heating, cooling and ventilation systems	
8. Glass and mirrors, including adjustment of mirrors	
9. Windshield wipers and washer	
10. All emergency equipment	
11. Tires, wheels, and lug nuts	
12. Brake system	
13. Parking brakes	
14. Vacuum gauge, ensuring it read less than 15 inches	
15. Low vacuum warning device	
16 Brake pedal	

Monthly CSW Contact Log

Child:_____

Date	Time	Person Contacted	Staff Initials

Message/Comments:_____

Date	Time	Person Contacted	Staff Initials

Message/Comments:_____

Date	Time	Person Contacted	Staff Initials

Message/Comments:_____

Person Responsible for Implementing Plan of Correction:
Facility Case Manager

Person Responsible for Monitoring to Ensure Corrective Action Remains Implemented and is Working as Intended:
Administrator

8. (Section # 10) Personnel Records:

SECTION CITED
59) -Were DOJ, FBI, and Child Abuse Clearance Indexes (CACI) submitted prior to employee's hired date? (SAFETY)
#61) -Do GH staff who have direct contact with children meet the educational/experience requirements? (SAFETY)
#62) -Have employees received timely health screenings ffB clearances? (SAFETY)
#65)-Have appropriate employees received all required training (initial, minimum of one-hour child abuse reporting, CPR, First-Aid, required annual, and emergency intervention)? (SAFETY)

Implemented Immediately

Current Facility assigned Administrator and HR Director will ensure that all documentation and requirements according to Title 22 and DFCS SOW is completed in the time frame stated in the specific policies and procedures. In addition the HR Director will make sure that all experience and education check are validated. The Administrator will ensure that all required training is completed and documented appropriately. The agency maintains a comprehensive training log that documents all training including First aid/CPR and Emergency Intervention refresher training the log also includes attendance records, trainers qualifications, handout and sing-in sheets.

Plan To Prevent Reoccurrence:
Administrator and HR Director will worked together to ensure that all personal files are complete, accurate and stay up to date at al/ times.

Person Responsible for Implementing Plan of Correction:
Administrator

Person Responsible for Monitoring to Ensure Corrective Action Rremains Implemented and is Working as Intended
Administrator and Director

Sincerely,
Carolyn C. [illegible], Director

Person Responsible for Monitoring to Ensure Corrective Action Remains Implemented and is Working as Intended:
Administrator and Program Director

(Section #7) Personal Rights and Social/Emotional Well-Being

#37)-Do children feel safe in the group home? (SAFETY)

Implemented Immediately
#37)

Effective immediately Facility Case Managers will be available to discuss any issues that resident may have in regards to their participation and living environment at the group Home. The Case Managers has the authority to make any necessary changes he/she deems appropriate to ensure that all resident feel safe and will be successful in their program participation. Additionally, staff will continue to encourage residents to attend and participate in resident council meeting as another outlet to discuss their issues.

Plan To Prevent Reoccurrence:
Effective immediately Facility Case Managers will be available every day to discuss any issues that resident may have in regards to their participation and living environment at the group home. The Case Managers will have the authority to make any necessary changes he/she deems appropriate to ensure that all residents feel safe and will be successful in their program participation. Additionally, staff will continue to encourage residents to attend and participate in resident council meeting as another outlet to discuss their issues.

Person Responsible for Implementing Plan of Correction:
Facility Case Manager, Facility Social Worker , Facility Manager

Person Responsible for Monitoring to Ensure Corrective Action Remains Implemented and is Working as Intended:
Administrator
(Section #8) Personal Needs/Survival and Economic Well-Being
SECTION CITED
#49)-Is at least $50 per month clothing allowance provided? (WELL-BEING)
#53) -Are children always provided with the minimum monetary allowances? (SELF-SUFFICIENCY)

Implemented Immediately
Facility Manager will be responsible to request from the finance department weekly, resident weekly and monthly clothing allowance (when applicable) and ensure that the amounts are documented correctly and resident's signatures are obtained. Staff will ensure that the residents will have an opportunities to use their monies to purchase needed clothing.

Plan To Prevent Reoccurrence:
Facility Case Manager will ensure that youth are receiving their monthly clothing and weekly allowances as specified in the GH program Statement and SOW.