COUNTY OF LOS ANGELES
PROBATION DEPARTMENT

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JERRY E. POWERS
Chief Probation Officer

August 17, 2015

TO: Supervisor Michael D. Antonovich, Mayor
Supervisor Hilda L. Solis
Supervisor Mark Ridley-Thomas
Supervisor Sheila Kuehl
Supervisor Don Knabe

FROM: Jerry E. Powers
Chief Probation Officer

SUBJECT: **BAYFRONT YOUTH & FAMILY SERVICES GROUP HOME CONTRACT COMPLIANCE MONITORING REVIEW**

The Department of Probation, Placement Permanency & Quality Assurance (PPQA), Group Home Monitoring (GHM), conducted a review of Bayfront Youth & Family Services (BYFS) Group Home, operated by Bayfront Youth & Family Services, in January 2015. BYFS has one (1) site located in the Fourth Supervisorial District of Los Angeles County. They provide services to Los Angeles County Probation, Department of Children and Family Services (DCFS), and Out of County foster children. According to BYFS program statement, its purpose is to provide residential care and treatment to children who require an intensive, structured mental health treatment program.

BYFS is a 40-bed site and is licensed to serve a capacity of 22 girls and 18 boys, 11-17 years old. At the time of this review, BFYS served two (2) Los Angeles County Probation foster children, nine (9) DCFS foster children, and 22 Out of County foster children. Based on the sample, the placed children's overall average length of placement was five (5) months, and their average age was 16 years old.

Seven (7) children, two (2) Probation and five (5) DCFS children, were randomly selected for the interview sample. All seven (7) children in the sample were prescribed psychotropic medication, and those cases were reviewed for timeliness of Psychotropic Medication Authorizations (PMAs) and to confirm the required documentation of psychiatric monitoring. Additionally, two (2) Probation and two (2) DCFS discharged children's files were reviewed to assess compliance with permanency efforts, and four (4) staff files were also reviewed for compliance with Title 22 Regulations and County Contract Requirements.

SUMMARY

During the PPQA/GHM review, the interviewed children generally reported feeling safe at BYFS, and that they were provided with good care and appropriate services, were comfortable in their environment and treated with respect and dignity. BYFS was in compliance with six (6) of the 10 areas of our Contract Compliance Review: "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".

Although, PPQA/GHM noted deficiencies in four (4) of the 10 areas, there was only one (1) area of safety concern related to improper restraints for which the agency was cited by Community Care Licensing (CCL), and a Corrective Action Plan (CAP) was required. BYFS did not make significant improvements from the previous annual review. In the area of "Licensure/Contract Requirements", BYFS needed to ensure that its agency is in compliance with CCL, Title 22 Regulations, regarding the use of improper restraints by employees and to ensure that their employees follow proper protocol when dispensing psychotropic medication to children prior to the court's approval of the JV 220. It was noted in the area of "Facility and Environment" that BYFS needed to make minor repairs and ensure that the worn mattresses and missing electrical plate cover are replaced in the bedrooms and common areas. In the area of "Maintenance of Required Documentation and Service Delivery", BYFS failed to develop comprehensive Needs and Services Plans (NSPs). In the area of "Educational and Workforce Readiness", BYFS needed to ensure that children are making progress towards their academic goals and school attendance.

REVIEW OF REPORT

On March 12, 2015, Probation PPQA Monitor Leng Lim held an Exit Conference with BYFS Administrator Lonnie Moody. Administrator Moody agreed with the review findings and recommendations and was receptive to implementing systemic changes to improve their compliance with regulatory standards, as well as address the noted deficiencies in a Corrective Action Plan (CAP).

BYFS Group Home provided the attached approved CAP addressing the recommendations noted in this compliance report. A follow-up visit was conducted and all deficiencies cited in the CAP were corrected or systems were put in place to avoid future deficiencies. Assessment for continued implementation of recommendations will be conducted during the next monitoring review.

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

If additional information is needed or any questions or concerns arise, please contact Director Lisa Campbell-Motton, Placement Permanency and Quality Assurance, at (323) 240-2435.

JEP:MEP:REB
LCM:ed

Attachments

c: Sachi A. Hamai, Interim Chief Executive Officer
John Naimo, Auditor-Controller
Phillip L. Browning, Director, Department of Children and Family Services
Public Information Office
Audit Committee
Sybil Brand Commission
Latasha Howard, Probation Contracts
Lonnie Moody, Bayfront Administrator
Community Care Licensing

BAYFRONT YOUTH & FAMILY SERVICES
CONTRACT COMPLIANCE MONITORING REVIEW SUMMARY

4151 FOUNTAIN STREET
LONG BEACH, CA 90804
LICENSE NUMBER: 197803075
RATE CLASSIFICATION LEVEL: 14

	Contract Compliance Monitoring Review	**Findings: January 2015**
I	**Licensure/Contract Requirements** (9 Elements)	
	1. Timely Notification for Child's Relocation	1. Full Compliance
	2. Transportation Needs Met	2. Full Compliance
	3. Vehicle Maintained In Good Repair	3. Full Compliance
	4. Timely, Cross-Reported SIRs	4. Full Compliance
	5. Disaster Drills Conducted & Logs Maintained	5. Full Compliance
	6. Runaway Procedures	6. Full Compliance
	7. Comprehensive Monetary and Clothing Allowance Logs Maintained	7. Full Compliance
	8. Detailed Sign In/Out Logs for Placed Children	8. Full Compliance
	9. CCL Complaints on Safety/Plant Deficiencies	9. Improvement Needed
II	**Facility and Environment** (5 Elements)	
	1. Exterior Well Maintained	1. Full Compliance
	2. Common Areas Maintained	2. Improvement Needed
	3. Children's Bedrooms	3. Improvement Needed
	4. Sufficient Recreational Equipment/Educational Resources	4. Full Compliance
	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. Full Compliance
	2. County 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. Improvement Needed
	5. Therapeutic Services Received	5. Full Compliance
	6. Recommended Assessment/Evaluations Implemented	6. Full Compliance
	7. County 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 Maintained 4. Children's Academic or Attendance Increased 5. GH Encouraged Children's Participation in YDS/ Vocational Programs	1. Full Compliance 2. Full Compliance 3. Full Compliance 4. Improvement Needed 5. Full Compliance
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 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. Reasonable Chores 10. Children Informed About Their Medication and Right to Refuse Medication 11. Children Free to Receive or Reject Voluntary Medical, Dental and Psychiatric Care 12. Children Given Opportunities to Plan Activities in Extra-Curricular, Enrichment and Social Activities (GH, School, Community) 13. Children Given Opportunities to Participate in Extra-Curricular, Enrichment and Social Activities (GH, School, Community)	Full Compliance (ALL)

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 Involved in Selection of Their Clothing 4. Provision of Clean Towels and Adequate Ethnic Personal Care Items 5. Minimum Monetary Allowances 6. Management of Allowance/Earnings 7. Encouragement and Assistance with Life Book	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)

DRAFT

BAYFRONT YOUTH & FAMILY SERVICES GROUP HOME
CONTRACT COMPLIANCE MONITORING REVIEW
FISCAL YEAR 2014-2015

SCOPE OF REVIEW

The purpose of this review was to assess Bayfront Youth & Family Services' (BYFS) compliance with the County contract and State regulations and include a review of the BYFS 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
- Personnel Records

For the purpose of this review, seven (7) placed children were randomly selected for the sample, which included two (2) Probation and five (5) DCFS children. Placement Permanency & Quality Assurance (PPQA), Group Home Monitoring (GHM) interviewed each child and reviewed their case files to assess the care and services they received. At the time of this review, all children in the sample were prescribed psychotropic medications. Their case files were reviewed to assess for timeliness of Psychotropic Medication Authorizations (PMAs) and to confirm the required documentation of psychiatric monitoring. Additionally, four (4) discharged children's files, which included two (2) Probation and two (2) DCFS were reviewed, to assess BYFS compliance with permanency efforts

Four (4) staff files were reviewed for compliance with Title 22 Regulations and County contract requirements, and a site visit was conducted to assess the provision of quality care and supervision.

CONTRACTUAL COMPLIANCE

The following four (4) areas were out of compliance.

Licensure/Contract Requirements

- During the review, it was noted that Community Care Licensing (CCL) received two (2) substantiated complaints against BYFS on Safety Deficiencies for the fiscal year 2014-2015. BYFS received one (1) citation in September 2014, for improper use of restraint by an employee on a child that was substantiated by CCL. A Corrective Action Plan (CAP) was submitted to CCL to address the deficiency. CCL substantiated another complaint against BYFS in January 2015, for failing to follow protocols by dispensing psychotropic medications to children

prior to the court's approval of the JV 220. A CAP was submitted to CCL to address the deficiency.

Recommendation

BYFS's management shall ensure that:

1. All staff continues to strive to be free of substantiated complaints by adhering to all Community Care Licensing Regulations and Standards, as set forth by Title 22 Regulations, Master County Contract, and BYFS's policy on the use of "Pro-Act" and "Proper Psychotropic Medication Protocol".

Facility and Environment

An inspection of the interiors and exteriors of BYFS revealed some cosmetic deficiencies that require correction in the Common Areas and Children's Bedrooms as follows:

- The vinyl baseboard molding was loose in the Dining Room. In the Girl's Community Bathroom, there was a loose toilet seat in stall #5. In the Boy's Community Bathroom, the left urinal stall does not flush.

- In the Girl's Bedroom #101, the dresser cabinet magnet catch was missing. In the Girl's Bedroom #102, there was a mattress severely worn out. In the Boy's Bedroom #203, there was another mattress worn out. In the Boy's Bedroom #204, there was an electrical reciprocal cover plate missing. In the Boy's Bedroom #207, there was damage to the previously repaired wall.

Recommendation

BFYS management shall ensure that:

1. All of the aforementioned physical plant deficiencies cited in the common areas are corrected and repaired in accordance with the CCL, Title 22 Regulations, which states that all Group Home sites are to be "clean, safe, sanitary and in good repair at all times."

2. All of the aforementioned physical plant deficiencies cited in the children's bedrooms are corrected and repaired in accordance with the CCL, Title 22 Regulations, which states that all Group Home sites are to be "clean, safe, sanitary and in good repair at all times."

Maintenance of Required Documentation and Service Delivery

- Of the seven (7) children's files reviewed, two (2) files revealed that the children have not progressed towards meeting their case goals, due to their continued or increased negative behaviors. Therefore, BYFS was not in compliant with the element, "Children Progressing Towards Meeting NSP Case Goals?"

- Of the seven (7) files reviewed, six (6) files lacked comprehensive Initial NSPs that did not include all the required elements in accordance with the NSP template. For the first file reviewed, the Initial NSP had two (2) different Case Plan Goal (Family Reunification and PPLA/Transition) boxes checked off instead of one; the "Educational Goal" was listed as one of the child's Outcome Goals, and the "Specific Goal, Plan and Services, and Method" sections were left incomplete. On a second file reviewed, the Initial NSP lacked the date when the initial dental exam was completed, date when the PMA was authorized, had the wrong goals listed for the child's "Permanency Planning" goals, and the "Educational" goals were incomplete. On a third file reviewed, the Initial NSP lacked the date when the child was enrolled in school and lacked an "Independent Living Program" Outcome Goal since the child is 17.5 years old. On a fourth file reviewed, the Initial NSP listed an "Educational Goal" as one of the Outcome Goals, and the "Specific Goal, Plan and Services, and Method" sections were left incomplete. On a fifth file reviewed, the Initial NSP had two (2) different Case Plan Goal (Family Reunification and PPLA/Transition) boxes checked off instead of one; incorrectly listed the child's "Treatment Plan" instead of a "Visitation Plan" for the family, and listed an "Educational Goal" as one of the Outcome Goals, and the "Specific Goal, Plan and Services, and Method" sections were left incomplete. On a sixth file reviewed, the Initial NSP lacked explanation as to why the child was not enrolled in school within three (3) days.

- Of the seven (7) files reviewed, six (6) files lacked comprehensive Updated NSPs that did not include all the required elements in accordance with the NSP template. For the first file reviewed, the Updated NSP lacked dates when the child's family and best friend visited her Face-to-Face at BYFS, and the "Educational Goal" was listed as one of the child's Outcome Goals, and the "Specific Goal, Plan and Services, and Method" sections were left incomplete. On a second file reviewed, the Updated NSP lacked a "Concurrent Case Plan" goal; lacked information addressing the family's participation with the child's case plan; had the Outcome Goals #1 & #2 mixed up; no changes were made to the child's case plan goals when she was not progressing towards meeting her goals; and listed an "Educational Goal" as one of the Outcome Goals and the "Specific Goal, Plan and Services, and Method" sections were left incomplete. On a third file reviewed, the Updated NSP lacked an "Independent Living Program" Outcome Goal since the child is 17.5 years old and dates when the child's family visited the child Face-to-Face at BYFS. On the fourth file reviewed, the Updated NSP had two (2) different Case Plan Goals (Family Reunification and PPLA/Transition) boxes checked off instead of one; lacked the parent's signature on the signature page and incorrectly listed the child's "Treatment Plan" instead of a "Visitation Plan" for the family. On the fifth file reviewed, the Updated NSP had two (2) different Case Plan Goals (Family Reunification and PPLA/Transition) boxes checked off instead of one; incorrectly listed the child's "Treatment Plan" instead of a "Visitation Plan" for the family; and lacked dates when the child's family visited the child Face-to-Face at BYFS. On the sixth file reviewed, the Updated NSP indicated no changes were made to the child's case plan goals when the child was not progressing towards meeting her case plan goals; failed to provide any quarterly updates on the "Adjustment to Placement"

and "Educational Goals" sections and lacked an "Independent Living Program" Outcome Goal since the child is 17.5 years old.

Recommendation

BYFS management shall ensure that:

1. All children placed have the opportunity to progress towards meeting their Case Plan Goals. BYFS shall modify or make necessary changes to the child's Case Plan Goals to make them more achievable when the child is not progressing towards meeting the goals, in accordance with the CCL, Title 22 Regulations, and the Master County Contract.

2. The aforementioned NSP deficiencies are corrected so that each child has comprehensive Initial NSPs, in accordance with the CCL, Title 22 Regulations, and the Master County Contract. BYFS Supervising Clinician shall review all Initial NSPs prior to the final distribution.

3. The aforementioned NSP deficiencies are corrected so that each child has a comprehensive Updated NSP, in accordance with the CCL, Title 22 Regulations, and the Master County Contract. BYFS Supervising Clinician shall review all Updated NSPs prior to the final distribution.

Education and Workforce Readiness

- A review of the files indicated that three (3) of the seven (7) children were not in compliance with the element of "Children's Academic or Attendance Increased?" All three (3) children's Updated NSPs indicated the children continue to have issues with poor school performance and attendance. Additionally, BYFS did not document the efforts made to assist the children in improving their school performance or implementing additional techniques as part of the Case Plan Goal modification.

Recommendation

BYFS management shall ensure that:

1. All efforts made by the Group Home to assist the children in making educational progress are clearly documented in the NSPs, in accordance with the CCL, Title 22 Regulations, and the Master County Contract

PRIOR YEAR FOLLOW-UP FROM THE PROBATION PPQA GHM GROUP HOME CONTRACT COMPLIANCE MONITORING REVIEW

The Department of Children and Family Services (DCFS) completed a compliance report for BYFS for the fiscal year 2013-2014. The last compliance report dated June 17, 2014, identified six (6) recommendations.

Results

Based on the follow-up, BYFS fully implemented three (3) of the six (6) previous recommendations for which they were to ensure that:

- The Group Home documents efforts to obtain the DCFS CSW's or DPO's authorization to implement the NSP. The Group Home shall document all efforts made to obtain the DCFS CSW's authorization to implement NSPs.

- DCFS CSWs or DPOs are contacted monthly by the Group Home and the contacts are appropriately documented in the children's case files.

- The Psychotropic Medication Authorizations are court-approved for children who are prescribed psychotropic medication.

However, the follow-up discovered that BYFS failed to fully implement three (3) of the previous six (6) recommendations for which they were to ensure that:

- The Group Home is in compliance with Title 22 Regulations and County contract requirements and remains free from CCL citations.

- 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

BYFS management shall ensure that:

1. The outstanding recommendations from the 2013-14 monitoring report dated June 17, 2014, which are noted in the previous report as Recommendations 1, 4, and 5, are fully implemented.

MOST RECENT FISCAL REVIEW CONDUCTED BY THE AUDITOR-CONTROLLER

A current fiscal review of the Group Home by the Auditor Controller is underway for the 2014-2015, fiscal year. A report has not yet been posted by the Auditor Controller.

Bayfront Youth & Family Services

"Changing lives is what we do!"

Craig Childress, Psy.D.
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7/1/2015

Leng Lim, Deputy Probation Officer II
Los Angeles County Probation Department
Placement Permanency & Quality Assurance
Group Home Monitoring & Investigations Unit
Lynnwood Regional Justice Center
11701 South Alameda St., 2nd Floor
Lynwood, CA 90262

DPO Lim,

Bayfront Youth and Family Services, RCL 14 Group Home, appreciates the opportunity to share in the responsibility of caring for youth placed in our care. Our agency recently underwent a Monitoring Review conducted by you on January 20, 2015 on behalf of the Los Angeles Department of Probation and Department of Children and Family Services. A Corrective Action Plan was implemented immediately following your review by Lonnie Moody, Administrator. Training and improvement will happen on continuous basis to ensure Bayfront Youth and Family Services meets the expectations of the Los Angeles Department of Probation and Department of Children and Family Services. Below are the results and action taken to correct all deficiencies.

Bayfront Youth & Family Services (BYFS) Deficiency Report for 2014-15 Monitoring Review

I. Licensure/Contract Requirements:

CCL Complaints on Safety/Plant Deficiencies: Community Care Licensing Program Analyst (LPA) Leon Thompson reported there were two Substantiated Complaints against BYFS, which resulted in one citation being issued and a Corrective Action Plan (CAP) submitted regarding the use of Improper Restraint by staff on a child that occurred on September 2014. The second substantiated complaint occurred on January 2015, where BYFS staff did not follow protocols by dispensing psychotropic medications to children prior to the court approving the JV-220 application. The citation and CAP are currently pending.

Recommendation: BYFS shall take all necessary actions to comply with the Community Care Licensing (CCL), Title 22 Regulations, and ensure that all employees received proper training to avoid future reoccurrences.

Cause of improper Restraint:: During the restraint, the staff performed an Improper Restraint on his or her own practice and was not consistent with Bayfront's Pro-Act training and procedures

Corrective Action:

All Bayfront Youth and Family Services staff will go through Pro-Act annually instead of Bi-Annually. All instances of restraints will be monitored by the Manager on duty and/or the Charge Nurse to ensure the safety of the clients and the staff. After all restraints the clients will be assessed by the Charge Nurse for injuries and if there are injuries the action taken by the Charge Nurse will be documented and a change of condition initiated per protocol. Bayfront Youth and Family Services currently has in place an On-Call Weekend Manager procedure to provide oversight of the facility and staff on the weekends. The On-Call managers are administrative staff or supervisors from other Bayfront Youth and Family Services entities. Each manager is responsible for making an unannounced visit to the Residential Program on their assigned day and complete a report of their findings. In addition to completing a report the mangers are task with interacting with the youth and listening to comments, complaints or suggestions and bringing them to the attention of the manager on duty as well as noting them in their report. If there are any issues that require immediate attention the Weekend On-Call Manager contacts the Administrator and relays the concern. In addition to the Weekend On-Call Manager visits, the Administrator and the Director of Residential Services routinely make unannounced visits to the facility outside of normal working hours.

Cause of not following protocol when dispensing Psychotropic Medication: The process for administering psychotropic medication on an emergency basis was not clearly defined in the program statement.

Corrective Action:

Administering Psychotropic Medication on an Emergency Basis.

Bayfront Youth and Family Services will follow the guidelines for Administering Psychotropic medication as outlined on the JV220. Bayfront Youth and Family Services will ensure the language used in requesting the emergency use clearly identifies the need for the emergency use as outlined in the California Rules of Court for administering psychotropic medication. Bayfront Youth and Family Service has added additional safe guard to ensure

the forms are being completed correctly and forwarded to the appropriate agencies. To ensure this does not occur in the future, all completed JV220s will be reviewed by the Administrator or his/her designee prior to being forwarded for approval. The Nursing Supervisor who is responsible for preparation of JV220s and all parties involved in this process including the psychiatrist have been trained on the procedure and language necessary for emergency use of psychotropic medication. Bayfront has submitted these changes to the program statement to CCL for approval.

Quality Assurance: *Lonnie Moody, Administrator will be responsible for oversight in this area and he or his designee will review all JV220's prior to being submitted for approval.*

II. Facility and Environment:

1. **Area of Non-Compliance: Common Areas Maintained:** Loose vinyl baseboard molding on the wall with a window in the Dining Room.

Root Cause: Normal wear and tear.

Recommendation: Repair the loose vinyl baseboard molding.

Corrective Action: Loose vinyl baseboard molding glued back on by Maintenance Dept. 1/20/2015.

Quality Assurance: Staff responsible for oversight is Maintenance Director Derek Strickland. Quality Assurance will be conducting daily, weekly and monthly facility checks.

2. **Area of Non-Compliance: Common Areas Maintained:** Loose toilet seat on stall #5 in the Girl's community bathroom.

Root Cause: Wear and tear from client use.

Recommendation: Tighten the loose toilet seat in stall #5.

Corrective Action : Toilet seat stall #5 tightened 1/20/2015 by Maintenance Dept.

Quality Assurance: Staff responsible for oversight is Maintenance Director Derek Strickland. Quality Assurance will be conducting daily, weekly and monthly facility checks.

3. **Area of Non-Compliance: Common Areas Maintained:** Left urinal stall does not flush in the boy's community bathroom.

Root Cause: Wear and tear from client use.

Recommendation: Repair left urinal stall to proper working order.

Corrective Action: Left Urinal stall repaired by Maintenance Dept. 1/22/2015.

Quality Assurance: Staff responsible for oversight is Maintenance Director Derek Strickland. Quality Assurance will be conducting daily, weekly and monthly facility checks.

4 **Area of Non-Compliance: Children's Bedroom (Girl's Unit):** One dresser cabinet magnet catch missing in Room 101.

Root Cause: Wear and tear from client use.

Recommendation: Replace missing cabinet magnet catch.

Corrective Action: Dresser cabinet magnet replaced on1/20/2015 by Maintenance Dept.

Quality Assurance: Staff responsible for oversight is Maintenance Director Derek Strickland. Quality Assurance will be conducting daily, weekly and monthly facility checks.

5. **Area of Non-Compliance: Children's Bedroom (Girl's Unit):** One child's mattress severely worn out in Room 102.

Root Cause: Normal wear and tear on mattress from client use.

Recommendation: Replace mattress with new one.

Corrective Action: Mattress replaced 3/12/2015 by Maintenance Dept.

Quality Assurance: Staff responsible for oversight is Maintenance Director Derek Strickland. Quality Assurance will be conducting daily, weekly and monthly facility checks.

6. **Area of Non-Compliance: Children's Bedroom (Boy's Unit):** One electrical reciprocal cover plate missing in Room 204.

Root Cause: Electrical reciprocal cover plate removed by client.

Recommendation: Replace missing electrical reciprocal cover plate.

Corrective Action: Electrical reciprocal cover replaced 1/20/2015 by Maintenance Dept.

Quality Assurance: Staff responsible for oversight is Maintenance Director Derek Strickland. Quality Assurance will be conducting daily, weekly and monthly facility checks.

7. **Area of Non- Compliance: Children's Bedroom (Boy's Unit):** One child's mattress is worn out in Room 203.

Root Cause: Normal wear and tear on mattress from client use.

Recommendation: Replace worn out mattress with new one.

Corrective Action: Mattress replaced 3/12/2015 by Maintenance Dept.

Quality Assurance: Staff responsible for oversight is Maintenance Director Derek Strickland. Quality Assurance will be conducting daily, weekly and monthly facility checks.

8. **Area of Non-Compliance: Children's Bedroom (Boy's Unit):** Previously repaired wall damaged in Room 207.

Root Cause: Property damage by clients.

Recommendation: Repair wall.

Corrective Action: Wall repaired 1/21/2015 by Maintenance Dept.

Quality Assurance: Staff responsible for oversight is Maintenance Director Derek Strickland. Quality Assurance will be conducting daily, weekly and monthly facility checks.

III. Maintenance of Required Documentation and Service Delivery:

1. Children progressing toward meeting NSP case goals. Two out of the seven Quarterly NSP reports reviewed indicated that the children did not progress towards meeting their case goals as evident that their negative behaviors continued to increase. **Root Cause:** Clinicians did not review client's efforts towards goal in detail and did not adjust case goals so that they are achievable and client specific.

   Recommendation: *BYFS shall take all necessary efforts to ensure that the child is progressing towards meeting their NSP case goals by decreasing negative behaviors. BYFS shall make any necessary adjustments to the child's case plan goals by increasing therapeutic services when determined that the child's behavior has not decreased during the quarterly reporting period.*

2. Development of Timely, Comprehensive Initial NSPs with Childs' Participation: Of the seven (7) files reviewed, six (6) files lacked

comprehensive detail on the Initial and Updated NSPs, in accordance with the required elements of the NSP. Two out of the seven children's Initial NSP reports reviewed had both the "Family Reunification" and "PPLA/Transition" box simultaneously checked off on the Case Plan Goals (Permanency) section.

Root Cause: Clinicians were not attentive to the directives on the NSP and were not comprehensive in their completion.

Recommendation: *BYFS clinicians completing the Initial NSP reports must only check off one box with the original permanency case plan goal and follow with a Concurrent Case Plan Goal. Clinicians shall ensure that all sections, areas, or boxes in the Initial NSP reports are comprehensively completed. Clinician must list the Permanency Planning, Educational Goal, and ILP Goal as part of the child's Outcome Goals in the Initial NSP reports. Clinical Supervisor shall provide quality assurance to ensure that all Initial NSP reports completed by the clinicians are comprehensive and Outcome Goals are child specific.*

3. Development of Timely, Comprehensive Updated NSPs with Child's Participation: Of the seven (7) files reviewed, six (6) files lacked comprehensive detail on the Initial and Updated NSPs, in accordance with the required elements of the NSP. One child's Updated NSP report listed the dates but did not address the participation of family and others in the child's treatment program over the past three months and did not describe involvement of child with other individuals (sister) who are important to the child over the past three months.

Root Cause: Clinicians did not consult with supervisor regarding how to correctly document information and supervisor did not catch the clinician's error.

Recommendation: *BYFS clinicians completing the Quarterly NSP reports must only check off one box with the original permanency case plan goal and follow with a Concurrent Case Plan Goal. Clinicians shall ensure that all sections, areas, or boxes in the Initial NSP reports are comprehensively completed. Clinician must list the Permanency Planning, Educational Goal, and ILP Goal as part of the child's Outcome Goals in the Initial NSP reports. Clinical Supervisor shall provide quality assurance to ensure that all Initial NSP reports completed by the clinicians are comprehensive and Outcome Goals are child specific.*

IV. Educational and Workforce Readiness

4. Children's Academics or Attendance Increased: Three out of the seven children's Quarterly NSP reports reviewed reflect that the children's Academics or Attendance were decreasing and BYFS did not provide any efforts to modify the child's Educational Goals. All three children's school attendances have decreased due to excessive absences, which have affected their academics.

   Root Cause: Clinicians did not document the monitoring of visitation and did not pay attention to details of client progress and educational goals nor were outcome goals modified. Supervisor did not catch the clinician's error.

   Recommendation: *BYFS shall take all necessary efforts to ensure that the child is progressing towards meeting their Educational Case*

   Goals by increasing attendances or academics. BYFS shall make any necessary adjustments by modifying the child's educational goals and the modifications will be individualized and based upon each child's ability and needs. Incentives may be implored in an effort to gain compliance, and or encourage greater attendance and participation in academics.

   Corrective Action Plan:

   On March 17, 2015 Bayfront Youth and Family Service's Clinical Director, Senior Social worker, Clinical Supervisor and Clinical Team met to review the findings of the probation monitors survey of the Initial NSPs and Quarterly reports. Social Services staff conducted training with the clinical staff utilizing probation monitors recommendations and sampled NSP report provided by DCFS and probation from the NSP Training. Effective immediately, to ensure that all NSP reports are comprehensive and thorough without deficits of pertinent information associated to client's case plan information, the clinician completing the report will first meet with the Senior Social Worker, Clinical supervisor, Administrator, Nursing staff and other treatment team members to gather information and input on the child's case plan prior to completing the NSP report. Information such as visitation dates, phone calls, doctor and dentist appointments, school enrollment date, life skill training, and sessions such as anger management, substance abuse, individual therapy sessions, Individual Education Plan meetings and SIRs. In addition, the clinician will ensure that each child's case plan goals are child specific by reviewing the child's case file thoroughly prior to preparing the Case Plan goals.

   Bayfront Youth and Family Services will consult with LA County Department of Mental Health representative Marion Spivey on July

16th to review current NSP documentation and receive training to improve the quality of NSP documentation.

Regarding each client's educational goals, Bayfront will continue to collaborate with the probation department to ensure the client is meeting conditions of probation. Bayfront will follow probations recommendations in relationship to client consequences for poor/lack of progress in academics. Bayfront will also do the following:

* Provide Tutor
* Reassess educational goals to determine metrics for progress
* Modify educational goals as needed

After a thorough review and clarification of client's progress, a clinician will now document when the child is not progressing toward his initial NSP goals. The clinician will make necessary modification to the case plan to stabilize the client which may include assigning clients to Bayfront's homework group, and/or requesting Therapeutic Behavioral Services if necessary.

Quality Assurance Plan (QAP)

In order to ensure future Initial and Quarterly NSP reports are comprehensive and child specific, Bayfront has implemented a three (3) step "Quality Assurance Process" The first step instructs the clinician writing the report to extensively review and proofread the report to ensure that all the required elements of the NSP template are completed with no blank areas. Secondly, the clinician will then have the NSP report read by the Senior Clinician for review to ensure that all the required elements of the NSP template was completed. Lastly, after the Senior Clinician has reviewed and approved the NSP, the report will be read for a third time by the Clinical Director prior to it being approved and distributed. If after all described measures are taken, and measurable improvement is not evident. The Director of Residential Services will take steps to ensure compliance. The following will be used as corrective measures to enhance outcomes

1. First occurrence: A documented review of training and understanding of the expectations for any clinician responsible for NSPs, to include a review of barriers if applicable, competency if needed, and a warning of the potential of a formal performance improvement plan to be initiated, for continual failure, to comprehensively document service provision and response to treatment.

2. Second occurrence: A written performance improvement plan will be initiated to ensure the clinician has a clear understanding of the objective, expectations, and outcome of a lack of compliance. To include a timeline for expected performance improvement.

3. A formal written counseling detailing the re-occurrence and the disciplinary action taken to gain compliance.

Lonnie Moody
Administrator
Bayfront Youth & Family Services