COUNTY OF LOS ANGELES
PROBATION DEPARTMENT

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CALVIN C. REMINGTON
Interim Chief Probation Officer

November 30, 2016

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

FROM: Calvin C. Remington Felicia Cotton for
Interim Chief Probation Officer

SUBJECT: **HAYNES FAMILY OF PROGRAMS (LEROY BOYS HOME) GROUP HOME CONTRACT COMPLIANCE MONITORING REVIEW**

The Department of Probation, Placement Permanency & Quality Assurance (PPQA), Group Home Monitoring (GHM), conducted a review of Leroy Boys Home (Leroys) Group Home, operated by Haynes Family of Programs (Haynes), in May 2016. Haynes Group Home has one (1) site, located in the Fifth Supervisorial District of Los Angeles County. Haynes Group Home provides services to Los Angeles County Probation foster children and the Department of Children and Family Services (DCFS) foster children. According to Haynes Group Home's program statement, its purpose is to provide intensive mental health services, milieu treatment and daily care to abused and troubled youth who have emotional and/or behavioral problems.

Haynes Group Home is a 36-bed site and is licensed to serve a capacity of 36 boys, 13-17 years of age, and Non-Minor Dependents. At the time of review, Haynes Group Home was serving 24 children (nine (9) Probation foster children and 15 DCFS foster children). Based on the sample size, the placed children's overall average length of placement was five (5) months, and their average age was 16 years old.

Seven (7) children were randomly selected for the interview sample (four (4) Probation foster children and three (3) DCFS foster children). There were two (2) DCFS foster children in the sample who 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, five (5) discharged children's files (three (3) Probation foster children and two (2) DCFS foster children) were reviewed to assess compliance with permanency efforts, and five (5) 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 Haynes Group Home, and that they were provided with good care and appropriate services, were comfortable in their environment and treated with respect and dignity. Haynes Group Home was in compliance with seven (7) of the 10 areas of the Contract Compliance Review: Licensure/ Contract Requirements, Education and Workforce Readiness; Health and Medical Needs; Psychotropic Medication; Personal Needs/Survival and Economic Well-Being; Discharged Children; and Personnel Records.

Although, PPQA/GHM noted deficiencies in three (3) out of the 10 areas, there were no egregious findings or child safety issue in any of the areas. It should also be noted that Haynes Group Home improved from the prior year review and had no repeat findings. In the area of Facility and Environment, Haynes Group Home needed to make minor repairs, and ensure that all common areas and children's bedrooms are adequately maintained. It was noted, in the area of Maintenance of Required Documentation and Service Delivery, Haynes Group Home needed to ensure that all Needs and Services Plans (NSPs) have the County Worker's signature to implement the NSPs and that all initial NSPs are comprehensive. In the area of Personal Rights and Social/ Emotional Well-Being, Haynes Group Home needed to ensure that children are provided with nutritious, palatable meals and snacks.

REVIEW OF REPORT

On May 31, 2016, Probation PPQA Monitor Joseph Ninofranco held an Exit Conference with the following Haynes Group Home Administrators: Quality Assurance Coordinator Joy Gahring; Mental Health Director Tisha Langley; Program Services Manager Corey Mitchell; Unit Manager Mario Flores; Campus Manager Shannine Crockett; Director of Operations Jim Taylor; Maintenance Supervisor Douglas Henton; Unit Manager William Harris; and Training Coordinator Frances Allain. The Haynes Group Home Administrators agreed with the review findings and recommendations and were 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).

Haynes Group Home provided the attached approved CAP addressing the recommendations noted in this compliance report. A follow-up visit was conducted on June 15, 2016, 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.

CCR:FC
LCM

Attachments

c: Sachi A. Hamai, Chief Executive Officer
Lori Glasgow, Executive Officer, Board of Supervisors
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
Frank Linebaugh, Haynes Family of Programs, Senior Vice-President
Joy Gahring, Haynes Family of Programs, Quality Assurance Coordinator
Community Care Licensing

HAYNES FAMILY OF PROGRAMS (LEROY BOYS HOME) GROUP HOME
CONTRACT COMPLIANCE MONITORING REVIEW SUMMARY

LICENSE NUMBER: 191501972
RATE CLASSIFICATION LEVEL: 12

	Contract Compliance Monitoring Review	Findings: May 2016
I	**Licensure/Contract Requirements** (9 Elements) 1. Timely Notification for Child's Relocation 2. Transportation Needs Met 3. Vehicle Maintained In Good Repair 4. Timely, Cross-Reported SIRs 5. Disaster Drills Conducted & Logs Maintained 6. Runaway Procedures 7. Comprehensive Monetary and Clothing Allowance Logs Maintained 8. Detailed Sign In/Out Logs for Placed Children 9. CCL Complaints on Safety/Plant Deficiencies	Full Compliance (ALL)
II	**Facility and Environment** (5 Elements) 1. Exterior Well Maintained 2. Common Areas Maintained 3. Children's Bedrooms 4. Sufficient Recreational Equipment/Educational Resources 5. Adequate Perishable and Non-Perishable Foods	1. Full Compliance 2. Improvement Needed 3. Improvement Needed 4. Full Compliance 5. Full Compliance
III	**Maintenance of Required Documentation and Service Delivery** (10 Elements) 1. Child Population Consistent with Capacity and Program Statement 2. County Worker's Authorization to Implement NSPs 3. NSPs Implemented and Discussed with Staff 4. Children Progressing Toward Meeting NSP Case Goals 5. Therapeutic Services Received 6. Recommended Assessment/Evaluations Implemented 7. County Workers Monthly Contacts Documented 8. Children Assisted in Maintaining Important Relationships	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. Development of Timely, Comprehensive Initial NSPs with Child's Participation 10. Development of Timely, Comprehensive, Updated NSPs with Child's Participation	9. Improvement Needed 10. Full Compliance
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	Full Compliance (ALL)
V	**Health and Medical Needs** (4 Elements) 1. Initial Medical Exams Conducted Timely 2. Follow-Up Medical Exams Conducted Timely 3. Initial Dental Exams Conducted Timely 4. Follow-Up Dental Exams Conducted Timely	Full Compliance (ALL)
VI	**Psychotropic Medication** (2 Elements) 1. Current Court Authorization for Administration of Psychotropic Medication 2. Current Psychiatric Evaluation Review	Full Compliance (ALL)
VII	**Personal Rights and Social/Emotional Well-Being** (13 Elements) 1. Children Informed of Group Home's Policies and Procedures 2. Children Feel Safe 3. Appropriate Staffing and Supervision 4. GH's efforts to provide 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	1. Full Compliance 2. Full Compliance 3. Full Compliance 4. Improvement Needed 5. Full Compliance 6. Full Compliance 7. Full Compliance 8. Full Compliance

	9. 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)	9. Full Compliance 10. Full Compliance 11. Full Compliance 12. Full Compliance 13. Full Compliance
VIII	**Personal Needs/Survival and Economic Well-Being** (7 Elements) 1. $50 Clothing Allowance 2. Adequate Quantity and Quality of Clothing Inventory 3. Children'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)

HAYNES FAMILY OF PROGRAMS (LEROY BOYS HOME) GROUP HOME CONTRACT COMPLIANCE MONITORING REVIEW FISCAL YEAR 2015-2016

SCOPE OF REVIEW

The purpose of this review was to assess Haynes Group Home's compliance with the County contract and State regulations and include a review of Haynes 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
- Personnel Records

For the purpose of this review, seven (7) placed children (four (4) Probation foster children and three (3) Department of Children and Family Services (DCFS) foster children) were randomly selected for the sample. 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 the review, two (2) placed DCFS foster children were prescribed psychotropic medication. Their case files were reviewed to assess for timeliness of Psychotropic Medication Authorizations (PMAs) and to confirm the required documentation of psychiatric monitoring. Additionally, five (5) discharged children's files (three (3) Probation foster children and two (2) DCFS foster children) were reviewed, to assess Haynes Group Home's compliance with permanency efforts.

Five (5) 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 three (3) areas were out of compliance.

Facility and Environment

An inspection of the interiors and common areas of Haynes Group Home revealed some cosmetic deficiencies that require correction.

At Haynes Group Home, there was a ripped screen in the common area, the living room of Wittry Cottage.

At Haynes Group Home, there were deficiencies noted in the children's bedrooms. In Burton Cottage, Bedroom #3 had a desk that contained graffiti; Bedroom #5 had a desk that contained graffiti; Bedroom #6 had loose bed bolts, graffiti in the closet, and a hole in the desk drawer. In Dow Cottage, Bedroom #1 had graffiti on the curtain and desk.

Recommendation

Haynes Group Home's management shall ensure that:

1. The aforementioned physical deficiency cited in the common area be corrected and repaired in a timely fashion. In addition, the common areas are to be maintained daily.

2. All of the aforementioned physical deficiencies cited in the children's bedrooms are corrected and repaired in a timely fashion. In addition, the children's bedrooms are to be maintained daily.

Maintenance of Required Documentation and Service Delivery

Seven (7) of the children's files were reviewed for Needs and Services Plans (NSPs), and of those, only four (4) children were placed long enough to have any updated NSPs in their file. Therefore, only four (4) of the children had both initial and updated NSPs reviewed, and three (3) of the children had only initial NSPs reviewed.

Of the updated NSPs reviewed for four (4) children, one (1) updated NSP lacked the County worker's authorization to implement the NSP.

Of the initial NSPs reviewed for seven (7) children, four (4) initial NSPs lacked comprehension. The first initial NSP was deemed non-comprehensive due to the fact that the Mental Health section was left blank, and Outcome Goal #3 did not detail an achievable goal for the child. The second initial NSP was deemed non-comprehensive due to the fact that the Case Plan Goal and the Concurrent Case Plan Goal sections were incomplete, Outcome Goal #3 did not articulate an achievable goal for the child, and Outcome Goal #6 was incomplete. The third

initial NSP was deemed non-comprehensive due to the fact that Outcome Goal #2 did not detail an achievable goal for the child, and the County Worker's signature was signed six months after the NSP was dated. The fourth initial NSP was deemed non-comprehensive due to the fact that the Concurrent Case Plan Goal section did not address why adoption or legal guardianship were not options for the child's future placement, the Medical/ Physical/ Dental Health section was left blank, the Mental health section was left blank, and Outcome Goal #2 did not detail an achievable goal for the child.

Recommendation

Haynes Group Home's management shall ensure that:

1. All County Worker's signatures authorizing implementation of the NSP are documented on the NSP.

2. The Group Home treatment team develops comprehensive initial NSPs, with the participation of the developmentally age-appropriate child.

Personal Rights and Social/Emotional Well-Being

During the interview process, one (1) of the seven (7) children stated that he did not like the food at the Group Home. Another child indicated that the food tasted bad, and although this child reported that he liked the food, he reported that there was too much chicken on the menu.

Recommendation

Haynes Group Home's management shall ensure that:

1. All children are provided with a variety of palatable meals and snacks.

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

PPQA/GHM's last compliance report dated August 17, 2015, identified six (6) recommendations.

Results

Based on the follow-up, Haynes Group Home implemented all six (6) of the previous recommendations for which they were to ensure that:

- All vehicles used by the Group Home were in good working order.

- All of the physical deficiencies previously cited in the Group Home's common areas were corrected and repaired.
- All of the physical deficiencies previously cited in the Group Home's children's bedrooms were corrected and repaired.
- There were an adequate amount of perishable and non-perishable foods, with dates of expirations clearly shown on the packages.
- All children are progressing towards meeting their NSP Case Goals.
- All children are provided with Life Books.

MOST RECENT FISCAL REVIEW CONDUCTED BY THE AUDITOR-CONTROLLER

A current fiscal review of Haynes Group Home by the Auditor Controller was conducted during the 2014-2015, fiscal year. The report has not yet been posted by the Auditor Controller.

Haynes Family of Programs
Leroy Boys Home
233 W. Baseline Road
La Verne, CA 91750
License Number: 191501972
Los Angeles County Probation Department
Group Home Monitoring Review
Corrective Action Plan
June 29, 2016

The Agency appreciates the collaborative relationship that has been developed with the Probation Department and continues to welcome the feedback provided as part of the Group Home Monitoring Review Process.

The following Corrective Action Plans (CAP's) requested on the Probation Group Home Monitoring Review Field Exit Summary dated May 31, 2016 have been developed and implemented.

II. Area of Review: Facility and Environment

Findings

1. The physical plan inspection noted the following deficiencies:

Common quarters were not well maintained

Wittry Cottage

- Ripped screen in living room

Children's bedrooms are not well maintained

Burton Cottage

- Bedroom number 3 has graffiti in desk
- Bedroom number 5 has graffiti in desk
- Bedroom number 6 has loose bed bolts, graffiti in closet and a hole in the desk

Dow Cottage

- Bedroom number 1 has graffiti on curtain and desk

Cause of Non-Compliance

The Burton, Wittry and Dow Cottage Unit Managers failed to note the physical plant deficiencies and graffiti in their cottages during their daily cottage walkthrough inspection.

Corrective Action Plan

All graffiti was removed, ripped living room screen was replaced, loose bed bolt tightened, and the hole in the desk was repaired. This was verified by DPO Joseph Ninofranco during a follow-up visit to the agency on June 14, 2016.

The Burton and Wittry Cottage Unit Managers was counseled by the Campus Manager regarding the importance of checking for graffiti, property damage and maintenance related issues during their daily cottage walkthrough. The Dow Unit Manager is no longer employed by the agency so he could not be counseled.

The Daily Walkthrough Standards were revised to reflect the need for managers to specifically check for property damage, safety hazards and graffiti in bedrooms during their daily walkthrough.

The Campus Manager will ensure that monthly unannounced cottage inspections are conducted as part of a plan to ensure that the agency maintains ongoing compliance with all requirements for the maintenance of the cottages.

Please reference Exhibit A for revised Daily Walkthrough Standards

This plan has been implemented.

Person Responsible for implementation: Shannine Crockett, Campus Manager

III. Area of Review: Maintenance of Required Documentation and Service Delivery

Finding 1

The Group home did not obtain or document efforts to obtain the CSW's authorization to implement the Needs and Services Plan, The NSP of one placed youth was missing the County worker's signature and there was only one e-mail attempt made to obtain the signature of the county worker to authorize implementation of the NSP. In addition, the CSW signature on one placed child's youth NSP was six month's late.

Cause of Non-Compliance

The Quality Assurance (QA) Coordinator is responsible for ensuring compliance with all NSP requirements. The previous Residential Director had not informed the QA Coordinator of the change in the requirement for agencies to go up the chain of command when a DCFS CSW did not respond to requests for approval of NSP's.

This was a change that occurred after the previous review in January 2014. Per Pamela Pease, Supervising DPO, this was discussed and reinforced at many previous provider meetings. These meetings were attended by the previous Residential Director but he failed to communicate this to the QA Coordinator and as a result, the QA Coordinator could not develop and implement a plan to ensure compliance with this requirement.

Corrective Action Plan Finding 1

The agency Campus Manager attends all provider meetings. The Campus Manager now provides a written report to the Senior Vice-President, Director of Mental Health Services, and QA Coordinator, following all provider meetings. The report includes details regarding new or changing requirements for Needs and Services Plan documentation.

The QA Coordinator has implemented a tracking system to ensure that written authorization to implement all NSP's is obtained from the County Worker. Two e-mail attempts will be made to obtain written authorization. When the County Worker does not respond within 10 business days of the e-mail request, notification will be made to the County Worker's supervisor via email.

This plan has been implemented

Person Responsible for implementation: Shannine Crockett, Campus Manager
Joy Gahring, QA Coordinator

Finding 2

The agency did not develop comprehensive, Initial Needs and Services Plans as follows:

- Child 1: The Mental Health section was left blank. Goal number 3 did not detail an achievable goal.
- Child 3: The Case Plan Goal section and the Concurrent Case Plan Goal section are incomplete. The Group Home should develop the youth's Case Plan and Concurrent Case Plan. Outcome goal 3 did not address the

youth's behavior. Outcome Goal 6: The Group Home should develop a permanency plan with the youth.

- Child 6: Outcome Goal 2 did not obtain an achievable goal.
- Child 7: The Concurrent Case Plan Goal section did not address why adoption or legal guardianship are not options for the youth's future placement. The Medical/Physical/Dental Health section was blank. The Mental Health section was blank. Goal 2 did not detail an achievable goal.

<u>Cause of Non-Compliance</u>

<u>Mental Health and Medical/Physical/Dental Health sections</u>

The agency nursing staff are responsible for completing these sections on all NSP's and failed to complete the NSP's correctly. These were errors of omission. The QA Coordinator was not routinely checking NSP documentation completed by nursing staff because prior compliance with these requirements was substantial. It is important to note that the Mental Health information section of Initial NSP's is related only to Psychotropic Medication and Psychotropic Medication Authorizations and does not include any other mental health service information.

<u>Case Plan and Concurrent Case Plan Goals</u>

The Agency did not receive this information from the County workers as requested. The Agency was not aware that it was our responsibility to determine the Case Plan and Concurrent Case Plan goals when this information is not provided by the County Worker or to ensure that the Concurrent Case Plan goal addresses why adoption or legal guardianship are not options for future placement.

<u>Outcome Goals</u>

The goals that were not correctly formatted were developed by the Unit Managers. Unit Managers have all been trained extensively regarding the need to create goals using the SMART goal format and failed to follow this format in the 4 goals in question. The QA Coordinator is responsible for the review of all NSP's before submission to County Workers. The QA Coordinator failed to note these deficiencies during her review of the NSP's and as result, could not direct the Unit Manager to format the goals correctly.

<u>Corrective Action Plan Finding 2</u>

<u>Mental Health and Medical/Physical/Dental Health sections</u>

a. The QA Coordinator will review the Mental Health and Medical/Physical/Dental Health sections of all NSP's to ensure that they

are completed. The QA Coordinator will notify the Health Services Manager/RN when these sections of NSP's are not completed so that they can be completed prior to submission of the NSP.

b. The QA Coordinator will provide an NSP training to nursing staff, Unit Managers, Child Advocates and Unit Managers on July 28. The training will include details regarding the importance of completing all sections of the NSP.

c. Ongoing lack of compliance by nursing staff with NSP completion will be addressed as a performance issue.

This plan has been implemented with the exception of the NSP Training which is scheduled for July 28, 2016.

Person Responsible for implementation: Joy Gahring, QA Coordinator
Rebecca Kolb, RN, MSN, PHN
Health Services Manager

Case Plan and Concurrent Case Plan Goals

a. The Unit Manager will continue to request the Case Plan and Concurrent Case Plan Goals from the County worker within 10 days of each youth's intake to the agency and will maintain a record of all requests. When the County worker does not provide this information by the 20th day following placement, their supervisor will be notified with a request for assistance and a record made of this request.

b. The Agency Treatment Team, including Unit Manager, Child Advocate, Therapist, youth and parent (when indicated), will develop the Case Plan and Concurrent Case Plan Goals only when all attempts to obtain this information from the County worker and/or supervisor have failed. The Unit Manager will ensure that the Case Plan and Concurrent Case Plan Goal sections of the NSP are completed.

c. When indicated, the Unit Manager will ensure that the Concurrent Case Plan Goal reflects permanency (adoption, legal guardianship or Family Finding), or the documentation reflects why these are not options for future placement.

d. The QA Coordinator will provide an NSP training to nursing staff, Unit Managers, Child Advocates and Unit Managers on July 28. The training will include all requirements related to Case Plan and Concurrent Case Plan goals.

e. The QA Coordinator will review the Case Plan and Concurrent Case Plan Goal sections of all NSP's to ensure that they are completed correctly.

This plan has been implemented with the exception of the NSP Training which is scheduled for July 28, 2016.

Person Responsible for implementation: Joy Gahring, QA Coordinator

Outcome Goals

a. The QA Coordinator will provide an NSP training to nursing staff, Unit Managers, Child Advocates and Unit Managers on July 28. The training will include a review of how to use the SMART Goal format for the development of measurable and achievable goals.

b. The QA Coordinator will ensure that she reviews every NSP carefully to ensure that NSP goals are formatted correctly, are measurable, and achievable.

c. Ongoing lack of compliance by Unit Managers staff with goal formatting requirements will be addressed as a performance issue.

This plan has been implemented with the exception of the NSP Training which is scheduled for July 28, 2016.

Person Responsible for implementation: Joy Gahring, QA Coordinator
Shannine Crockett, Campus Manager

VII. Area of Review: Personal Rights and Social/Emotional Well Being

Finding

One youth reported that the food was "horrible" and a second youth reported that too much chicken was served.

Cause of Non-Compliance

The agency strives to balance the need for healthy and nutritious meals with the desires of teenage boys who often would prefer to eat pizza, hamburgers, or fast food at every meal.

Corrective Action Plan

The Agency will continue to ensure that the following existing plans are followed as part of our effort to provide nutritious, palatable meals and snacks:

1. The contracted food service provider provides a wide variety of food choices at every meal so youth have the choice of more than one entrée at each meal if they do not like the main entrée.

2. The Agency Youth Leadership Council is comprised of two youth from each cottage. The cottage representative's role is to report feedback and concerns from youth regarding a wide variety of topics, including concerns related to food served at the agency. All feedback from youth regarding food is forwarded to the food services manager. Whenever possible, the food services manager utilizes this feedback in menu planning.

3. Youth are offered the opportunity to learn to cook and prepare meals of their choosing as part of Life Skills Training.

4. Youth are able to enjoy their favorite foods on community based outings.

This plan has been implemented

Person Responsible for implementation: Shannine Crockett, Campus Manager

Respectfully Submitted,

Frank Linebaugh
Senior Vice-President

EXHIBIT A

Haynes Family of Programs
DAILY WALK THROUGH STANDARDS
Revised June 2016

A. HALLWAY BULLETIN BOARDS
1. List of Resident's Personal Rights
2. Menu
3. Daily Schedule – Sunday through Saturday
4. Evacuation Plan, Map, and Procedures
5. Bedroom Roster (list Resident's first name and first initial of last name only)
6. Cleanliness of Bulletin Board Items

B. BATHROOMS
1. Cleanliness
2. Check Light Fixtures
3. Check that there are no clogged toilets/showers
4. Check to ensure that toilet plunger is stored in the lock up
5. Check to ensure that there are no cleaning supplies left out
6. Check to ensure that there are no hygiene supplies left
7. Check for broken window blinds
8. Check for broken shower doors and mirrors
9. Check to ensure that the floors are not slippery
10. Check to ensure that soap dispenser is in working order
11. Check to ensure that towel dispenser is in working order
12. Check to ensure that there is toilet paper in the bathroom stalls

C. BEDROOMS
1. Check to ensure that the seven items that are supposed to be on bed are there. The seven items are:
   (a). Two (2) sheets
   (b). One (1) pillow case
   (c). Pillow
   (d). Mattress Pad
   (e). Comforter
   (f). Blanket
2. Check for contraband of any kind
3. **Check for property damage and safety hazards**
4. Check for broken window blinds
5. Check for any cracked windows
6. Check to ensure that the trash cans are empty
7. Check under the beds to ensure that they are free of storage and debris
8. Check to ensure that the bulletin boards have background paper and border. The bulletin boards need to have five items posted appropriately

9. Check to ensure that the floor has been vacuumed
10. Check laundry basket, ensure that there is no overflow
11. Check radios and televisions to ensure that they have been turned off
12. Check overhead closet and ensure that there is no overflow of personal belongings or trash
13. Check Resident's desk and ensure that it is free of clutter
14. Check dresser drawers to ensure that the items are folded and neatly organized
15. **Check for graffiti on walls, doors, inside drawers and closets**
16. Check to ensure that the furniture has been dusted
17. Check the strings on the blinds to ensure that they are not tied together and are single
18. Check to ensure that there is only one extension cord per appliance/device
19. Check to ensure lighting is adequate/blinds open

D. LIVING ROOM

1. Check to ensure that the living room has been vacuumed
2. Check under and around furniture for trash and under sofa cushions
3. Check to ensure that the trash cans have been emptied
4. Check to ensure that the floor has been swept and vacuumed
5. Check to ensure that the windows are cleaned
6. Check to ensure setting is homelike
7. Check to ensure lighting is adequate/blinds open

E. DINING ROOM

1. Check to ensure that the trash has been emptied
2. Check to ensure that the chairs are clean
3. Check to ensure that the floor has been swept/vacuumed
4. Check under the table for cleanliness
5. Check to ensure table has been wiped clean
6. Check to ensure that the fireplace has been cleaned
7. Check to ensure that the shelves have been dusted and wiped clean

F. KITCHEN

1. Check for thermometer in freezer and refrigerator (temperature should be 40 degrees.)
2. Check to ensure that all foods are labeled, dated, and tightly sealed. Check to ensure that there are no open food containers or open packaged food
3. Check for expired or stale food, they will need to be discarded
4. Check for overall cleanliness of refrigerator and freezer. Check to ensure that there are no stains of any kind.
5. Check counter tops to ensure that they are clean. Make sure there are no crumbs, stains, or splatters of any kind

4. Make sure brooms and dust pans are locked up and not left on tope shelves in the mudroom
5. Make sure that no dirty water is left sitting in the mop bucket and that the mop is rung out
6. Make sure laundry soap and all cleaning supplies are locked up

6. Check to ensure that there are no dirty dishes, pots, or pans. They should all be cleaned
7. Check microwave oven for cleanliness, both inside and outside, and underneath
8. Check to ensure that there are no cleaning supplies under the sink
9. Make sure floors are swept and mopped
10. Make sure dishtowels and dish cloths are washed on a regular basis
11. Kitchen Cabinet: Check to ensure that there are no unsealed boxes or packages. Leftovers must be put in covered containers or put in zip lock packages, and labeled with the date opened
12. Check stove for possible gas leaks
13. Check for cracked windows
14. Check for broken window blinds
15. Check trash can by the kitchen door to ensure that it has a lid
16. Check stove and oven to ensure they are clean
17. Check vent fan to ensure it is clean

G. <u>OUTSIDE OF UNIT</u>

1. Trash cans need to be tightly sealed
2. Check for odor(s)
3. Check back porch for cleanliness
4. Check for trash along side of cottage
5. Check to see that the sidewalk has been swept
6. Check to ensure that no clothing is outside
7. Check for graffiti on outside walls of cottage
8. Protective Separation Rooms: Check for cleanliness, and room should be locked when not in use
9. Check for cleaning supplies
10. Check patio table to ensure that it is cleaned and wiped

H. <u>MEDICATION LOCK UP</u>

1. Always ensure that no medications are left outside of the lock up
2. Check to ensure that the cabinets are locked at all times
3. If applicable, no storage of mop, bucket, or maintenance supplies
4. Check for flashlights (2)
5. Check for first aid kits (2)
6. Check Maintenance Log. Report outstanding maintenance requests to Director of Operations
7. Check for sufficient hygiene supplies (ensure that soap is stored in soap container and toothbrush is in toothbrush holder)
8. Ensure that the key to medication lock up is not stored in the closet

I. <u>LAUNDRY ROOM/MUDROOM</u>

1. Make sure room is swept and mopped.
2. Check for debris behind the washer and dryer
3. Make sure that no clothes are left in washer or dryer