COUNTY OF LOS ANGELES
PROBATION DEPARTMENT

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TERRI L. MCDONALD
Chief Probation Officer

April 11, 2017

TO: Supervisor Mark Ridley-Thomas, Chairman
Supervisor Hilda L. Solis
Supervisor Sheila Kuehl
Supervisor Janice Hahn
Supervisor Kathryn Barger

FROM: Terri L. McDonald
Chief Probation Officer

SUBJECT: **FLORENCE CRITTENTON SERVICES OF ORANGE COUNTY, INC., CRITTENTON SERVICES FOR CHILDREN AND FAMILIES GROUP HOME CONTRACT COMPLIANCE MONITORING REVIEW**

The Department of Probation, Placement Permanency & Quality Assurance (PPQA), Group Home Monitoring (GHM), conducted a review of Crittenton Services for Children and Families Group Home, operated by Florence Crittenton Services of Orange County, Incorporated, in September 2016. Crittenton Services for Children and Families has one site, the Valley View campus, and is located in Orange County. They provide services to Los Angeles County Probation foster children and the Department of Children and Family Services (DCFS) foster children. According to the Crittenton Services for Children and Families program statement, its purpose is designed to treat clients who are physically, sexually and emotionally abused and neglected. The program is also intended to treat pregnant and parenting clients, clients who are delinquent in their behavior and clients who require psychotropic medication.

Crittenton Services for Children and Families is a 91-bed site and is licensed to serve a capacity of 54 girls, 12-17.5 years of age and Non Minor Dependents (NMDs), and have a capacity of 37 children from birth to four (4) years of age. At the time of review, Crittenton Services for Children and Families served 15 Los Angeles County Probation foster children and their four (4) children, and 21 DCFS foster children and their six (6) children. The overall length of placement was four (4) months, and their average age was 16 years old. For the sample size, the seven (7) placed children's overall average length of placement was three (3) months, and their average age was 17 years old.

Seven (7) children were randomly selected for the interview sample, three (3) Probation foster children and four (4) DCFS foster children; however, one (1) Probation foster child was not interviewed due to being released from the Group Home prior to the interview. There were three (3) children in the sample who were prescribed psychotropic medication, one (1) Probation foster child and two (2) DCFS foster children, and those cases were reviewed for timeliness of the Psychotropic Medication Authorization (PMA) and to confirm the required documentation of psychiatric monitoring. Additionally, three (3) discharged children's files, one (1) Probation foster child and two (2) DCFS foster children, were reviewed to access 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 Crittenton Services for Children and Families, they indicated that they were provided with good care, appropriate and effective services of quality, were comfortable in their environment, and treated with respect and dignity. Crittenton Services for Children and Families were in compliance with seven (7) of the 10 areas of our Contract Compliance Review: Education and Workforce Readiness; Health and Medical Needs; Psychotropic Medication; Personal Rights and Social/Emotional Well-Being; Personal Needs/Survival and Economic Well-Being; Discharged Children; and Personnel Files.

PPQA/GHM noted deficiencies in three (3) of the 10 areas; with six (6) out of 76 specific elements deficient within the areas. Although, there were no egregious findings or child safely issues in any of the areas, the same deficiencies from the last review period were in one (1) of the 10 areas, Maintenance of Required Documentation and Service Delivery.

In the area of Licensure/Contract Requirements, Crittenton Services for Children and Families needed to ensure that the facility remained free of substantiated Community Care Licensing Division (CCLD) complaints. In addition, they needed to make certain that all vehicles used to transport children are maintained in good repair and have passenger headrests. They also needed to ensure that weekly allowance logs are accurately maintained and contain all children's signatures. Furthermore, it was noted in the area of Facility and Environment that Crittenton Services for Children and Families needed to ensure that the exterior and the grounds of the Group Home are well maintained and that all the children's bedroom windows have protective screens.

Deficiencies were also noted in the area of Maintenance of Required Documentation and Service Delivery in that Crittenton Services for Children and Families needed to make certain that all Initial and Updated Needs and Service Plans (NSPs) are accurately completed.

REVIEW OF REPORT

On November 9, 2016, Probation PPQA Monitor Kedra Bracken held an Exit Conference with the following Crittenton Services for Children and Families Administrators: Vice President of Residential Services Barbara Hernandez; Program Director Erin Grierson; and Case Manager Coordinator Desiree Basurto. The 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).

Crittenton Services for Children and Families provided the attached approved CAP addressing the recommendations noted in this compliance report and explained how they will ensure that the repeated deficiencies of the same nature will be avoided. 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; however, an additional check will be required to ensure that permanent changes were made. 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.

TLM:FC
LCM:tj

Attachments

c: Sachi A. Hamai, Chief Executive Officer
John Naimo, Auditor-Controller
Phillip L. Browning, Director, Department of Children and Family Services
Terri L. McDonald, Chief, Department of Probation
Public Information Office
Audit Committee
Sybil Brand Commission
Community Care Licensing
Latasha Howard, Probation Contracts
Joyce Capelle, Crittenton Services for Children and Families Chief Executive Officer
Barbara Hernandez, Crittenton Services for Children and Families Vice President of Residential Services
Erin Grierson, Crittenton Services for Children and Families Program Director
Desiree Basurto, Crittenton Services for Children and Families Case Manager Coordinator

FLORENCE CRITTENTON SERVICES OF ORANGE COUNTY, INC.,
CRITTENTON SERVICES FOR CHILDREN AND FAMILIES GROUP HOME
CONTRACT COMPLIANCE REVIEW SUMMARY

Rate Classification Level 12
License Number: 300612972

	Contract Compliance Review	Findings: September 2016
I	**Licensure/Contract Requirements** (8 Elements)	
	1. The Group Home was free of any substantiated Community Care Licensing Division (CCLD) citations on child abuse/safety and/or physical deficiencies since the last review.	1. Improvement Needed
	2. Vehicles used to transport children are maintained in good repair.	2. Improvement Needed
	3. Disaster drills are conducted at least every six months and documented.	3. Full Compliance
	4. The runaway policy is documented and properly maintained.	4. Full Compliance
	5. Detailed sign-in/out logs are maintained.	5. Full Compliance
	6. Weekly allowance logs are accurately maintained.	6. Improvement Needed
	7. Monthly clothing allowance logs are accurately maintained.	7. Full Compliance
	8. Special Incident Reports (SIRs) documented in the Needs and Services Plans (NSPs) and case files and are properly reported via the ITrack system.	8. Full Compliance
II	**Facility and Environment** (5 Elements)	
	1. The exterior and the grounds of the Group Home are well maintained.	1. Improvement Needed
	2. Common quarters are well maintained.	2. Full Compliance
	3. Children's bedrooms are well maintained.	3. Full Compliance
	4. The Group Home maintains appropriate recreational equipment and educational resources (e.g. computer) in good repair and makes them readily available to children.	4. Full Compliance
	5. The Group Home maintains adequate nutritious perishable and non-perishable food.	5. Full Compliance

III	**Maintenance of Required Documentation and Service Delivery** (3 Elements) 1. The Initial NSP was completed accurately and on time. 2. The Updated NSPs were completed accurately and on time. 3. The Group Home provided children with counseling and other services (based on current NSPs).	1. Improvement Needed 2. Improvement Needed 3. Full Compliance
IV	**Education and Workforce Readiness** (3 Elements) 1. Children are enrolled in school within three school days. 2. The Group Home ensured the children attend school as required. 3. The Group Home ensures the children's report cards or progress reports, and if applicable, current copies of Individualized Education Programs (IEPs) are maintained in their files.	Full Compliance (ALL)
V	**Health and Medical Needs** (4 Elements) 1. Initial medical exams are conducted timely. 2. Initial dental exams are conducted timely. 3. Required follow-up medical examinations are conducted timely. 4. Required follow-up dental examinations are conducted timely.	Full Compliance (ALL)
VI	**Psychotropic Medication** (2 Elements) 1. Current Court-Approved Authorizations are on file. (Including accurate dosage) 2. Psychiatric Evaluation/Review (561c) is current.	Full Compliance (ALL)
VII	**Personal Rights and Social/Emotional Well-Being** (18 Elements) 1. Children are informed of the Group Home's rules and consequences. 2. Children report the consequences for not following the rules are fair.	Full Compliance (ALL)

	3. Children are informed of the Foster Youth Bill of Rights. 4. Children participate in the development of their NSPs. 5. Children are supervised by staff. 6. Children are treated with respect. 7. Children feel safe in the Group Home. 8. Children have an adult they can talk with privately. 9. Children are allowed to have private telephone calls and to send and receive unopened mail. 10. Children have privacy during the visits with family or close friends. 11. Children are offered the opportunity to participate in a mentorship program. 12. Children are allowed to attend or not attend religious services of their choice. 13. Children are given the opportunity to participate in planning recreational activities with the staff. 14. Children are given the opportunity to participate in recreational activities at the Group Home. 15. Children are given the opportunity to participate in extracurricular or community activities. 16. Children's chores are reasonable. 17. Children are informed about their rights to medical and dental treatment (right to refuse). 18. Children are informed about their right to refuse psychotropic medication.	
VIII	**Personal Needs/Survival and Economic Well-Being** (16 Elements) 1. Children are provided with medical care when needed. 2. Children are provided with dental care when needed. 3. Children are provided with transportation. 4. Children are encouraged and supported by staff in keeping a Life Book. 5. Children are assisted by adults in completing schoolwork when help is needed. 6. Children are provided with youth development or daily living skills services. 7. Children are provided with their own personal hygiene items.	Full Compliance (ALL)

	8. Children get enough food to eat. 9. Children with special diet needs are provided with accommodations by the staff. 10. Children receive at least the basic weekly allowance. 11. Children are free to spend their allowance, as long as they are appropriate purchases. 12. Children receive at least the basic clothing allowance. 13. Children are able to choose the clothes they buy, as long as they are appropriate. 14. Children have enough clothes to wear. 15. Children are supervised while in the pool area. 16. Children report the home is free of unsecured dangerous items.	
IX	**<u>Discharged Children</u>** (3 Elements) 1. The Group Home placed the child in accordance with their Program Statement and population criteria. 2. The Group Home discharged the child in accordance with the NSP permanency plan, or to a lower level of care. 3. The Group Home attempted to stabilize the child's placement prior to requesting a removal.	Full Compliance (ALL)
X	**<u>Personnel Records</u>** (14 Elements) 1. Staff signed a criminal record statement (LIC 508) prior to or on hire date. 2. Staff received criminal clearance from CCLD prior to hire date. 3. Staff received medical clearance within one year prior to hire date or within seven days after hire date. 4. Staff received tuberculosis (TB) clearance within one year prior to hire date or within seven days after hire date. 5. Staff met educational and/or experience requirements in accordance with the agency's Program Statement and Title 22 Regulations. 6. Staff signed the agency's policies, including confidentiality agreement and mandated reporter acknowledgment.	Full Compliance (ALL)

	7.	Staff had current California driver's license on file.	
	8.	Staff had current Cardiopulmonary Resuscitation (CPR) certification on file.	
	9.	Staff had current First Aid certification on file.	
	10.	Staff received initial emergency intervention training [e.g. Professional Assault Crisis Training (Pro--ACT)].	
	11.	Staff received initial 24 hour training (eight hours prior to supervision and 16 hours within 90 days of hire).	
	12.	Staff has current emergency intervention training on file (e.g. Pro-ACT).	
	13.	Staff received 20 hours of on-going training.	
	14.	If site has a pool or other body of water, there is at least one staff with current water safety certification on file.	

FLORENCE CRITTENTON SERVICES OF ORANGE COUNTY, INC.,
CRITTENTON SERVICES FOR CHILDREN AND FAMILIES GROUP HOME
CONTRACT COMPLIANCE MONITORING REVIEW
FISCAL YEAR 2016-2017

SCOPE OF REVIEW

The purpose of this review was to assess Crittenton Services for Children and Families compliance with the County contract and State regulations and include a review of Crittenton Services for Children and Families 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, three (3) Probation foster children and four (4) DCFS foster children, were randomly selected for the sample. Placement Permanency & Quality Assurance (PPQA), Group Home Monitoring (GHM), interviewed six (6) children and reviewed all of their case files, to assess the care and services they received. At the time of the review, three (3) placed children were prescribed psychotropic medication, one (1) Probation foster child and two (2) DCFS foster children. Their case files were reviewed to assess for timeliness of the Psychotropic Medication Authorization (PMA) and to confirm the required documentation of psychiatric monitoring. Additionally, three (3) discharged children's files, one (1) Probation foster child and two (2) DCFS foster children, were reviewed to assess Crittenton Services for Children and Families 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.

Licensure/Contract Requirements

Since the last review, Crittenton Services for Children and Families had two (2) substantiated Community Care Licensing Division (CCLD) citations on safety. On May 11, 2016, it was found that Crittenton Services for Children and Families failed to provide a safe environment for a parenting child's infant by not taking over responsibility of the infant when the parenting child could no longer provide safety for the infant. In addition, on July 15, 2016, it was determined that Crittenton Services for Children and Families failed to protect a child from self-harm because the Group Home did not take immediate medical action after the child disclosed that she had taken an undisclosed amount of medication.

The first substantiated CCL complaint was received on April 22, 2016. The Corrective Action Plan (CAP) was submitted to CCL on May 13, 2016. As a result, the Investigation was closed on May 11, 2016. The CAP detailed that, on May 13, 2016, all direct care staff was provided with training to review safety precautions to be taken when youth with their babies/children become escalated. The training included removing the child from the youth's care, if safe to do so, taking the child to another cottage to be respited until the youth de-escalates, and/or taking the child to the Parent and Child Education (PACE) Center to provide the youth and child space and time to calm down.

The second substantiated CCL complaint was received on June 17, 2016. The CAP was submitted to CCL on June 18, 2016. As a result, the Investigation was closed on July 15, 2016. The CAP detailed that on July 19, 2016, the Medical Procedure was refined to include clarifying details on how to follow the protocol that was already in place. The procedure included a more detailed description and instruction on calling poison control and getting additional medical clearances upon the disclosure of ingesting substances. All staff was trained by July 31, 2016.

During the inspection of the 10 facility vehicles at Crittenton Services for Children and Families, it was noted that one (1) vehicle did not have a passenger headrest.

During a review of the allowance logs, it was discovered that two (2) weekly logs were missing one child's signature of receipt. This was for the same child, and at the time of the review, Crittenton Services for Children and Families was unable to locate the signed logs; however, the child did receive her allowance on time for each week, as Crittenton Services for Children and Families was able to provide the signed logs at the Exit Conference.

Recommendation

Crittenton Services for Children and Families management shall ensure that:

1. The Group Home is free of substantiated Community Care Licensing Division (CCLD) citations on child abuse/safety and/or physical deficiencies.

2. All vehicles used to transport children are maintained in good repair and have passenger headrests.

3. Weekly allowance logs are accurately maintained and all children's signatures are obtained on the logs, to acknowledge receipt of allowance.

Facility and Environment

An inspection of the Crittenton Services for Children and Families facility revealed a deficiency to the exterior that required correction.

At the Valley View Campus, one (1) child's bedroom was missing an outside window screen.

Recommendation

Crittenton Services for Children and Families management shall ensure that:

1. The exterior and the grounds of the Group Home are well maintained, and all children's bedrooms have outside window screens.

Maintenance of Required Documentation and Service Delivery

Seven (7) of the children's files were reviewed, and of those, only three (3) children were placed long enough to have Updated Needs and Service Plans (NSPs) in their file. Therefore, three (3) children had Updated NSPs reviewed, and four (4) children had only Initial NSPs reviewed.

Of the seven (7) Initial NSPs reviewed, six (6) Initial NSPs lacked complete accuracy. The first Initial NSP reviewed was deemed inaccurate due to the fact that the Case Plan Goal section did not address why Family Reunification is not an option for the child's future placement, and the Goal section did not contain simplistic, specific and achievable goals. The second Initial NSP reviewed was considered inaccurate due to the fact that the Case Plan Goal section did not address why Family Reunification is not an option for the child's future placement, and the Goal section did not contain a measurable goal. The third

Initial NSP reviewed was considered inaccurate in that the Group Home failed to obtain the Deputy Probation Officer's (DPO) signature on the NSP within a timely manner (within five business days of completion of the NSP).

The fourth Initial NSP reviewed was considered inaccurate due to the fact that the Concurrent Case Plan Goal section did not address why adoption or legal guardianship are not acceptable options for the child's future placement, the Goal section did not contain a simplistic, and achievable goal, and the Group Home failed to obtain the DPO's signature on the NSP within a timely manner (within five business days of completion of the NSP). The fifth Initial NSP reviewed was considered inaccurate in that the Group Home failed to obtain the child's signature and the DPO's signature on the NSP within a timely manner (within five business days of completion of the NSP). The sixth Initial NSP reviewed was considered inaccurate due to the fact that the Case Plan Goal section did not address why Family Reunification is not an option for the child's future placement, the dental examination date on the NSP was incorrect, and the Goal section did not contain a simplistic and measurable goal.

Of the three (3) Updated NSPs reviewed, two (2) lacked full accuracy. The first Updated NSP reviewed was deemed inaccurate due to the fact that the Concurrent Case Plan Goal section did not address why adoption or legal guardianship are not acceptable options for the child's future placement and the Group Home failed to obtain the DPO's signature on the NSP within a timely manner (within five business days of completion of the NSP). The second Updated NSP reviewed was considered inaccurate due to the fact that the Case Plan Goal section was not updated.

Recommendation

Crittenton Services for Children and Families management shall ensure that:

1. The Group Home treatment team will develop accurate, Initial NSPs with the participation of the developmentally age-appropriate child.

2. The Group Home treatment team will develop accurate, Updated NSPs with the participation of the developmentally age-appropriate child.

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

PPQA/GHM's last compliance report dated May 27, 2016, identified seven (7) recommendations.

Results

Based on the follow-up, Crittenton Services for Children and Families fully implemented five (5) of the seven (7) previous recommendations for which they were to ensure that:

- 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 maintained daily.

- The Group Home treatment team will ensure that all County Worker's contact with the Group Home is documented.

- All children feel safe at the Group Home.

- All children shall be encouraged or assisted in creating and maintaining life books or photo albums upon arrival in the Group Home.

- All necessary paperwork and documents to verify each employee's mandatory training are valid and included in their personnel files.

However, the follow-up discovered that Crittenton Services for Children and Families failed to fully implement two (2) of the previous seven (7) recommendations for which they were to ensure that:

- The Group Home treatment team will develop accurate, Initial NSPs with the participation of the developmentally age-appropriate child.

- The Group Home treatment team will develop accurate, Updated NSPs with the participation of the developmentally age-appropriate child.

MOST RECENT FISCAL REVIEW CONDUCTED BY THE AUDITOR-CONTROLLER

A current fiscal review of Crittenton Services for Children and Families by the Auditor Controller was conducted during the 2015-2016, fiscal year. Although reported in previous Monitoring Compliance reports as being in progress for the 2014- 2015, fiscal year, the review was rescheduled and is currently in progress for the review period of April 1, 2015, thru March 31, 2016.

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Crittenton
services for children and families

December 28, 2016

County of Los Angeles
Department of Probation
Quality Assurance Division
c/o Kedra Frelix
11701 Alameda Street
Lynwood, CA 90262

Dear DPO Frelix,

Thank you for your review of our Valley View Campus this year. The following items have been addressed in the areas noted in the review findings:

SECTION I. LICENSURE/CONTRACT REQUIREMENTS

1. Noncompliance: The Group Home was free of any substantiated Community Care Licensing Division (CCLD) complaints.

   It was noted in the review that the group home had 2 substantiated allegations since the last review. Corrective Action Plans were submitted to CCLD Regional Office and implemented as follows:

   A. Although CCL noted in the investigative findings that an infant was left by his escalated mother (Valley View client) with a peer without adult supervision, upon review of the incident, it was further noted that the infant was either in the direct care of the staff or in the staff's sight at all times. At the time of the incident, staff was unable to safely acquire the infant from the client's peer, therefore, staff maintained line of sight with the infant and peer at all times. On the following dates, all residential counselors and direct care staff were provided an in-service training to review safety precautions to be taken when clients with babies/children become escalated: 06/09/16 and 06/13/16 (Please see attached sign in training rosters). This included, removing the child from the client's care if safe to do so, taking the child to another cottage to be respited until the client de-escalates, and/or taking the child to the Parent and Child Education (PACE) Center upstairs to provide the client and child space and time to calm down Although agency policy already identified these options as possible solutions in a scenario such as this, staff access to specific locations such as PACE was increased to include more direct care staff. All Corrective Action was completed and the issue will continue to be discussed in staff and program meetings as deemed necessary.

   B. CCL findings reflected a need for a more comprehensive response of a client who had reported ingesting excessive medications prior to placement at Valley View. The circumstances of the case are as follows: Upon

placement, the client reported to staff that she had ingested a quantity of 10 prescribed psychotropic medications prior to her placement at Crittenton. The client disclosed that she had ingested of the substance days prior to her placement at Crittenton and also waited to tell staff a few hours after being seen by both a pediatrician and nurses for initial routine health exam. Medical exam result indicated that her vitals were normal and the medical department did not have any medical concerns about her health based. Furthermore, upon disclosure, all agency protocol at the time was followed, including: the client being seen by a medical doctor hours before the disclosure, no symptomology present that would alert the MD, nurses and/or staff, the client being placed on a 1:1 watch immediately after the disclosure to monitor for any adverse reactions that would require prompt medical attention, continued daily assessment by licensed or license-eligible clinical staff. CCL found this allegation to be substantiated solely because the client was not re-examined upon the disclosure that occurred hours after already being seen by a doctor. Because of the specific circumstances surrounding these allegations, other investigating entities (Out-of-Home Care Unit) found the allegations to be unsubstantiated, with no need of further corrective action. Although our medical procedure already had clear directives on how to manage the ingestion of unknown substances and medical/medication, per the corrective action plan required by CCL, the Medical Procedure for Crittenton was refined to include additional clarifying details on how to follow the protocol already in place. These steps included a more detailed description and instruction on calling poison control and getting additional medical clearances upon the disclosure of ingesting non-prescribed medication, over self-medicating, and/or any unknown substances. The procedure was modified and approved effective 07/19/16. All staff were trained on the updated procedure on the following dates: 07/28/16, 07/29/16, 07/30/16, 07/31/16 (Please see attached sign in training rosters). All Corrective Action was completed and the issue will continue to be discussed in staff and program meetings as deemed necessary.

2. Noncompliance: Vehicles used to transport children are maintained in good repair.

   Cause: It was noted in the review that a head rest in one of the vans needed repair. The cause of the missing headrest is due to staff not completing a work order after following established vehicle procedure. The head rest was fixed during the audit, however, a verbal repair request was made versus a formal documented work order.

   A. Corrective Action, Implementation, and Quality Assurance: On or before 1/15/17, all staff who utilize agency vehicles to transport clients will be re-trained on timely submission of formal/documented vehicle work orders as well as the need for vehicle inspections before and after utilizing the vehicle. On site vehicles will be routinely inspected by maintenance and/or management staff for Quality Assurance purposes. The Director of Support Services will continue to ensure all safety deficiencies are corrected in a three tier system of importance: safety, licensing, and security.

   B. Responsible Parties: Director of Support Services, Program Director, Unit Supervisors for each cottage, Team Leaders and Maintenance Department

3. Noncompliance: Weekly allowance logs are accurately maintained.

   Cause: At the time of the review two allowance logs could not be located due to the responsible staff being on maternity leave and not completing necessary filing of documentation prior to going on maternity leave. After searching the locked cabinet of documents waiting to be filed, the documents were found and filed.

   A. Corrective Action, Implementation, and Quality Assurance: On or before, 1/15/17, all Team Leaders and Unit Supervisors will be re-trained on the need to file all documentation on a weekly basis. Unit Supervisors will insure filing by team leaders is being completed in a timely fashion through the use of monthly audits of client files.

   B. Responsible Parties: Team Leaders, Unit Supervisors, Clinical Director, Client Services Director, Program Director

SECTION II. FACILITY AND ENVIRONMENT

1. Noncompliance: Exterior of the grounds of the Group Home are well maintained.

   Cause: Review findings included window screens needing repair due to clients removing or destroying them. It should be noted that due to the nature of the business and the destructive behaviors of the clients, maintenance repairs on the daily wear and tear of the campus grounds and rooms is done on a rotation. Should the maintenance issue be identified as a health and safety issue, Maintenance Department will prioritize those issues first and get to the wear and tear as prioritized and on the rotation.

   A. Corrective Action, Implementation, and Quality Assurance: Work orders are constantly being submitted for all maintenance requests upon the grounds, including window screens. On or before 01/15/17, staff meetings will provide a training regarding the timely submission of work orders. The Director of Support Services will continue to ensure all safety deficiencies are corrected in a three tier system of importance; safety, licensing, and security. On ground inspections during bi-monthly walk through meetings will occur with maintenance and/or management staff as necessary.

   B. Responsible Parties: Director of Support Services, Program Director, Unit Supervisors for each cottage, Team Leaders and Maintenance Department

SECTION III. MAINTENANCE OF REQUIRED DOCUMENTATION AND SERVICE DELIVERY

1. The review noted specific discrepancies for individual clients' maintenance of required documentation and service delivery itemized in the report and addressed below.

   A. Noncompliance: Per the review, the case plan goals do not address why Family Reunification is not an option for children 1, 2, and 7; Case plan

section does not address why adoption and/ or legal guardianship is not an option for child 5 on initial & quarterly; case plan goal section not updated from initial to quarterly report for child 5.

Cause: In the cases noted above, the placing worker/court case plans indicated that family reunification, adoption, or legal guardianship were not an option. Therefore, to follow the directives of the placing worker/court case plan/709 documentation, the Needs and Services Plan was updated by the Case Manager to remain consistent with the outlined objectives of the placing worker and court.

a. Corrective Action, Implementation, and Quality Assurance: On or before 1/15/16, the Case Manager Coordinator will provide a refresher training course to the case management team aimed to review the process of examining the client's court documents and case plan summaries received from placing worker, discussing the permanency plan with the placing worker, and ultimately reflecting the agreed upon permanency plan on the Needs and Service Plan. In-service training will review that Family Reunification is "supposed to be the case plan for any child who is still in the first 12 months," of receiving out of home care. If the case plan identified by court, placing worker, and client continues to be disparate from a plan of Family Reunification, adoption, or legal guardianship, the case manager will follow the placing work and the courts directives and document the disparity in the NSP. Case Manager Coordinator and/or Lead Case Manager will review all NSP's to insure that any disparities between the "expectation" of the placing agency or court and the reality of what the client and placing worker request are adequately documented.

b. Responsible Parties: Case Managers, Case Manager Coordinator, Program Director

B. Noncompliance: Per the review: "Child 1's initial Goal #1 did not apply to the youth. NSP stated that she was not in school due to Maternity rest status."

Cause: Upon the client's arrival to placement, she was already on maternity rest. Due to the unpredictable nature of maternity rest, it is the agency's policy to insure that an educational goal of attending school is included in the initial NSP (the NSP reflected the client's ***need*** to attend school and graduate as well as the ***services*** needed to make that happen). This policy is to insure that the treatment team is proactive in addressing potential barriers to enrollment and attendance *prior* to the end of maternity rest and/or the NSP

reporting period. After review of the record, it was determined the client's initial educational goal should have included the caveat that the client would attend school once maternity rest was over.

a. Corrective Action, Implementation, Quality Assurance: The Case Management team will be trained no later than 01/15/17 to ensure NSPs are completed in an individualized fashion and ensure that educational goals include a caveat for those clients on maternity rest. Case Manager Coordinator and/or Lead Case Manager will review all NSP's to insure they are individualized for each client and are not generic.

b. Responsible Parties: Case Managers, Case Manager Coordinator, Program Director

C. Noncompliance: Child 1's initial Goal #4 is not achievable, goal was to participate and maintain sobriety 7x/week.

Cause: The client's court order required counseling for a history of substance use and upon clinical assessment it was discovered the client had a lengthy period of sobriety. In efforts to meet the court order requirements and address the assessment findings, the client's treatment team, including licensed clinical staff, agreed that it was in sound clinical judgment to develop a weekly goal vs. discharge the goal of sobriety all together. The rationale of the treatment team was to monitor the client every week to instill long term coping skills as an alternative to the client's previous pattern of turning to substances in times of stress.

a. Corrective Action, Implementation, Quality Assurance: When it is determined that a client has a substance abuse history (whether recent or more historical), clinical judgment and clinical treatment, as well as court documentation, for the need of specific chemical dependency services will determine the goal and what steps are taken to support the goal, in this case, sobriety. To ensure that Case Managers continue to depict a clear picture of the client's needs and services, on or before 01/15/17, the case management department will have an in-service aimed at reinforcing the need to document the client's individualized circumstances (including circumstances and requests identified in court documentation) and how they relate to the goals. All such information will continue to be included in the NSP in terms that the client can understand. Case Manager Coordinator and/or Lead Case Manger will review all NSP's to ensure that the rationale for the inclusion of a substance abuse goal is clearly identified within the NSP.

b. Responsible Parties: Case Managers, Case Manager Coordinator, Program Director

D. Noncompliance: Initial Psychological/Developmental/Behavioral goals for Child 1, Child 2, Child 5 and Child 7 were noted by reviewer as either not measurable or too complex.

Cause: The agency's procedure is that all Psychological/Developmental/Behavioral goals on the Needs and Service Plan match the therapeutic goal established by the assigned therapist upon the client's intake. Although the goal may have been perceived to be complex, Crittenton is a Residential Treatment Program, in which the mental health therapist and mental health paraprofessionals are working toward this goal with the client. The clients are well aware of their goals and are understanding of the rehabilitative nature of the program. Additionally, the goal on the Needs and Service Plan is the same goal that the Department of Mental Health requires to provide clinical services. This process ensures continuity of care and ensures clients do not have multiple conflicting therapeutic goals, which would be clinically unjustified as well as unethical.

a. Corrective Action, Implementation, Quality Assurance: To align with the continuum of care, as well as ethical treatment practices within a Residential Treatment Facility, the nature of the client's NSP Psychological Goal requires clinical judgement. Furthermore, the NSP Psychological Goal needs to match the psychological goal being utilized while providing day to day mental health services through DMH. The goals will continue to address specific behaviors that correspond with the clients' identified diagnoses. However, as a Continuous Quality Improvement (CQI) measure, case managers and therapists will ensure that they document in the NSP that the goal has been adequately explained and that the client and family members all understand the focus of treatment. Case Managers and therapists will be provided an in-service no later than 1/15/17 addressing the noted CQI.

b. Responsible Parties: Case Managers, Case Manager Coordinator, Program Director, Clinical Director, Therapists

E. Noncompliance: Child 7's dental examination date was incorrect in initial Needs and Service Plan.

Cause: The client's initial dental examination appointment, which was within the first 30 days of placement, was cancelled by the dental office after the

information (appointment date and time) were entered into the NSP. Furthermore, the dental office was unable to reschedule the exam until after the initial 30 days of placement. The 30 day NSP was unable to be corrected, as it was submitted for review right before the cancelation of the dental appointment. The following NSP would have been reflective of this information.

a. Corrective Action, Implementation, Quality Assurance: Case Manager Coordinator will collaborate with Medical services coordinator to determine the best method to improve communication of appointment cancellations prompted by any dental/medical office in a timely manner to the Case Management Department. Communication resolutions will then be addressed by 1/15/17 with all Medical Department and Case Management Department staff to begin implementation of suggested changes. Furthermore, any further issues of this nature will be identified and documented thoroughly in the NSP and will be reviewed by the Case Manager Coordinator.

b. Responsible Parties: Case Managers, Case Manager Coordinator, Program Director, Medical personnel, Medical Coordinator

F. Noncompliance: No DPO signature was documented for Child 1's NSP. NSPs for Child 4, Child 5, and Child 6 did not note obtainment of the placing workers signature within a timely manner.

Cause: Case managers requested to obtain signatures of placing workers multiple times through verbal requests prior to following up with placing workers via email requests, but were not successful due to placing workers' lack of responses. Further attempts to communicate with placing workers via email were also submitted for audit review. Placing worker for child 4 and 5 visited the clients at school and did not inform case manager of times when a visit would occur at school. Should the placing worker have notified the case manager of the off-site visit, then the documentation would have been brought to them for signature. In regards to child 6, the signature was obtained, but not within the designated time frames due to non-responsiveness to requests.

a. Corrective Action, Implementation, Quality Assurance: Case Manager Coordinator will review with Case Managers the options available to obtain a placing workers signature within 5 business days of NSP due dates via the refresher course offered to the case management department, to be completed by 01/15/17. Case Manager Coordinator will demonstrate the proper chain of command

to alert for support when no response is received from a child's placing worker directly. Per technical assistance provided at the exit interview, after contacting the placing worker for signature 2 to 3 times, the case manager is to contact the supervisor of the placing worker and, if there continues to be no response in obtaining the signature, the agency staff is to contact the regional administrator. Phone and email attempts will be made to reach both the placing worker and the supervisor prior to reaching the 5 day mark and will be documented.

b. Responsible Parties: Case Manager Coordinator, Program Director, Case Managers

G. Noncompliance: Child 6 signature was not obtained in a timely manner..

Cause: Due to scheduling issues with treatment team members as well as the client, the NSP was not signed by client in a timely manner.

a. Corrective Action, Implementation, Quality Assurance: In an effort to prevent a similar deficiency in the future, the case management team will review alternative methods to present NSP content to the Child in a simplified fashion as a final point in the refresher course noted to be completed by 01/15/17. Case Manager Coordinator will address utilization of a separate simplified goals page, nurturing voice tone, proper timing to request the Childs attention and focus on positive aspects of the treatment summary in place in order to enhance the Childs ability to successfully sign the document. In the event that the Child continues to refuse, Case managers will also be re-trained on the importance of documenting all attempts.

b. Responsible Parties: Case Manager Coordinator, Program Director, Case Managers

Crittenton Services is committed to providing exceptional services to each of our clients. I am confident that the corrective action plans that have been put into place, in conjunction with existing policies and procedures, will further educate our clients and staff members to continue to run an effective and viable program. Should there be any questions please call Erin Grierson, LMFT at (714) 680-8263 ext. 1004 or egrierson@crittentonsocal.org.

Sincerely,

Erin Grierson, MA, LMFT
Program Director

Dr. Barbara Hernandez, MA, Psy. D., LMFT, LPCC
Vice President of Residential Services