COUNTY OF LOS ANGELES
PROBATION DEPARTMENT

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(562) 940-2501

TERRI L. McDONALD
Chief Probation Officer

December 5, 2017

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

FROM: Terri L. McDonald
Chief Probation Officer

SUBJECT: **TRINITY YOUTH SERVICES GROUP HOME CONTRACT COMPLIANCE MONITORING REVIEW**

The Department of Probation, Placement Permanency & Quality Assurance (PPQA), Group Home Monitoring (GHM), conducted a review of Trinity Youth Services (TYS) Group Home, operated by Trinity Youth Services, Inc., in March 2017. TYS has three (3) sites: TYS-El Monte located in the First Supervisorial District of Los Angeles County, TYS-Apple Valley located in the in the First Supervisorial District of San Bernardino County, and TYS-Yucaipa located in the Third Supervisorial District of San Bernardino. TYS provides services to Los Angeles County Probation foster children and Probation foster children from outside counties. According to TYS' program statement, its purpose is to treat children who exhibit behavior, social and emotional difficulties.

TYS-El Monte is a 43-bed site and is licensed to serve a capacity of 43 boys, 13-18 years old. TYS-Apple Valley is a 44-bed site and is licensed to serve a capacity of 44 boys, 13-18 years old. TYS-Yucaipa is a 48-bed site and is licensed to serve a capacity of 48 boys, 13-18 years old. At the time of review, TYS was serving 51 Los Angeles County Probation children at the three (3) sites. Their average length of placement was seven (7) months, and their average age was 16 years old. For the interview sample size of placed children, their average length of placement was five (5) months, and their average age was 16 years old.

Seven (7) of children were randomly selected for the interview sample. There were four (4) children in the sample who were prescribed psychotropic medication, and those cases were reviewed for timeliness of Psychotropic Medication Authorization (PMAs) and to confirm the required documentation of psychiatric monitoring. Additionally, four (4)

discharged children's files were reviewed to access compliance with permanency efforts, and six (6) staff files were also reviewed for compliance with Title 22 Regulation and County Contract Requirements.

SUMMARY

During the PPQA/GHM review, the interviewed children generally reported feeling safe at all three (3) TYS sites, and that they were provided with good care, appropriate and effective services of quality, were comfortable in their environment and treated with respect and dignity. TYS was in compliance with seven (7) of the 10 areas of our Contract Compliance Review: "Educational and Workforce Readiness", "Health and Medical Needs", "Psychotropic Medication", "Personal Rights and Social/Emotional Well-Being", "Personal Needs/Survival and Economic Well-Being", "Discharged Children" and "Personnel Records".

PPQA/GHM noted deficiencies in three (3) of the 10 areas; with six (6) deficient elements out of 76 specific elements within the 10 areas. Although, there were no egregious findings or child safety issues in any of the areas, the same deficiencies from the last review period were in three (3) of the 10 areas. In the area of "Licensure/Contract Requirement", TYS needed to ensure that two (2) transportation vehicles at Trinity Yucaipa have new tires and two (2) other vehicles at Trinity Apple Valley repair the loose carpeting. In addition, TYS needed to ensure that its agency is free from Community Care Licensing (CCL) complaints for late reporting of Special Incident Report and for a medical procedure being administered by non-certified professional. It was noted, in the area of "Facility and Environment" that TYS needed to make minor repairs to ensure that the cracked concrete slab on the exterior at TYS-Yucaipa is repaired and the presence of mold is removed in the showers of the common quarter bathrooms in two (2) different dorms at TYS Apple Valley.

Deficiencies were also noted in the area of "Maintenance of Required Documentation and Service Delivery", in that TYS needs to ensure that the children's Initial and Updated Needs and Services Plan are comprehensive and meet the SMART Goals guidelines.

REVIEW OF REPORT

On May 3, 2017, Probation PPQA Monitor Leng Lim held an Exit Conference with TYS Administrators Gilbert Quinbar and Elizabeth Tamoush. Administrators Quinbar and Tamoush 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).

TYS 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 the CCL.

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:SEM:FC
LD:LCM:tj

Attachments (3)

c: Sachi A. Hamai, Chief Executive Officer
John Naimo, Auditor-Controller
Bobby Cagle, Department of Children and Family Services
Public Information Office
Audit Committee
Sybil Brand Commission
Community Care Licensing
Latasha Howard, Probation Contracts
Gilbert Quinbar, Campus Director, Trinity Youth Services
Elizabeth Tamoush, Campus Director, Trinity Youth Services

TRINITY YOUTH SERVICES GROUP HOME
CONTRACT COMPLIANCE MONITORING REVIEW SUMMARY

Trinity Apple Valley
License Number: 366401747
Rate Classification Level: 12

Trinity Yucaipa
License Number: 360900416
Rate Classification Level: 12

Trinity El Monte
License Number: 191591941
Rate Classification Level: 12

	Contract Compliance Monitoring Review	Findings: March 2017
I	**Licensure/Contract Requirements** (8 Elements)	
	1. The Group Home was free of any substantiated Community Care Licensing Division (CCLD) complaints 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. Full Compliance
	7. Monthly clothing allowance logs are accurately maintained.	7. Full Compliance
	8. SIRs documented in the NSPs and case files being properly reported via the I-track 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. Improvement Needed
	3. Children's bedrooms are well maintained.	3. Full Compliance
	4. The Group Home maintains adequate recreational equipment and educational resources in good repair and makes them readily available to children.	4. Full Compliance
	5. The Group Home maintains adequate nutritious perishable and non-perishable foods.	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	**Educational and Workforce Readiness** (3 Elements) 1. Children are enrolled in school within three school days. 2. The Group Home ensures 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 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/Reviews (561c) are 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. 3. Children are informed of the Foster Youth Bill of Rights.	Full Compliance (ALL)

	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 received unopened mail. 10. Children have privacy during the visits with family or close friends. 11. Children are offered to participate in 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. 8. Children get enough food to eat. 9. Children with special diet needs are provided with accommodations by the staff.	Full Compliance (ALL)

	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	**Discharged Children** (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	**Personnel Records** (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 1 year prior to hire date or within seven days after hire date. 4. Staff received TB clearance within 1 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. 6. Staff signed the agency's policies, including confidentiality agreement and mandated reporter acknowledgement. 7. Staff had current California driver's license on file. 8. Staff had current CPR certification on file. 9. Staff had current First Aid certification on file. 10. Staff received initial emergency intervention training (e.g. Pro-ACT).	Full Compliance (ALL)

	11. Staff received initial 24 hour training (8 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.	

TRINITY YOUTH SERVICES GROUP HOME
CONTRACT COMPLIANCE MONITORING REVIEW
FISCAL YEAR 2016-2017

SCOPE OF REVIEW

The purpose of this review was to assess Trinity Youth Services (TYS) compliance with the County contract and State regulations and include a review of the Trinity Youth Services 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. 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, four (4) placed 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, four (4) Probation discharged children's files were reviewed to assess Trinity Youth Services' compliance with permanency efforts.

Six (6) 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

During the review, it was noted that the Department of Social Services, Community Care Licensing Division (CCLD) reported two (2) Substantiated Complaints against TYS. CCL reported a Substantiated Complaint against TYS-

El Monte on December 14, 2016, for Reporting Requirements regarding a late reporting of a Special Incident Report (SIR) involving a Probation youth that occurred on October 23, 2016. CCL received the SIR via the Incident Tracking System (a-Track) on November 3, 2016. TYS was not cited; however, a Corrective Action Plan (CAP) was submitted to CCL to address the deficiency.

CCL reported another Substantiated Complaint against TYS-Yucaipa on December 20, 2016, for a Personal Rights Violation where a medical procedure (enema) was administered by a non-certified professional, a Certified Nursing Assistant (CNA). According to Title-22, an enema can only be administered by a Registered Nurse (RN) or a physician. TYS was not cited; however, a CAP was submitted to CCL to address the deficiency. Therefore, TYS-El Monte and TYS-Yucaipa were not in compliance with the element, "The Group Home was free of any substantiated Community Care Licensing Division (CCLD) complaints on child abuse/safety and/or physical deficiencies since the last review?"

During an inspection of the transportation vehicles at TYS-Apple Valley, it was noted that two (2) vans had loose carpeting that was not intact to the floor pans on the first passenger row. It was also noted that at TYS-Yucaipa, one (1) van had low thread wear on both front tires and another van had low thread wear on the front right tire. Therefore, TYS-Apple Valley and TYS-Yucaipa were not in compliance with the element, "Vehicles used to transport children are maintained in good repair?"

Recommendation

Trinity Youth Services management shall ensure that:

1. The Group Home was free of any substantiated Community Care Licensing Division (CCLD) complaints on child abuse/safety and/or physical deficiencies since the last review.

2. Vehicles used to transport children are maintained in good repair with loose carpets repaired and all worn tires are replaced as recommended National Highway Traffic Safety Administration (NHTSA) and to be in compliance with the Master County Contract, Statement of Work (SOW), which states that the Contractor shall "abide by all applicable federal and state laws and regulations in transporting Placed Children."

Facility and Environment

An inspection of the interiors and exteriors of Trinity Youth Services revealed some cosmetic deficiencies that require correction to the Exterior and Common Quarters.

At TYS-Yucaipa, there was a large piece of concrete slab that cracked in half and shifted unevenly off the ground; located on the walkway between the parking lot and basketball court. Therefore, TYS-Yucaipa was not in compliance with the element, "The exterior and the grounds of the Group Home are well maintained?"

At TYS-Apple Valley, there was presence of mold around the shower pan and shower walls in the Bruin's Dorm, Restroom C. There was also presence of mold over the old caulking on the shower pan in the Aztec's Dorm, Restroom C. Therefore, TYS-Apple Valley was not in compliance with the element, "Common quarters are well maintained?"

Recommendation

Trinity Youth Services management shall ensure that:

1. The exterior and the grounds of the Group Home are well maintained.

2. Common quarters are well maintained.

Maintenance of Required Documentation and Service Delivery

Seven (7) children's files were reviewed for Needs and Service Plans (NSP) compliance, and of those, only six (6) children were placed long enough to have an Updated NSP in their file. Therefore, only six of the children had Updated NSPs reviewed, and all seven (7) children had Initial NSPs reviewed.

Of the seven (7) Initial NSPs reviewed, two (2) from TYS-Yucaipa had incorrect dates for when the children were enrolled in school. The school dates were documented incorrectly by the therapist; however, the children were enrolled in school within three (3) days of their arrival to TYS-Yucaipa.

Of the seven (7) Initial NSPs reviewed, one (1) from TYS-El Monte had the wrong Permanency Case Plan Goals checked off. The Family Reunification (F/R) box should have been checked off instead of the PPLA/Transition box, as there was no record in the child's history or file, showing that F/R had already been established at the child's previous placement. TYS-El Monte reported that they misunderstood this section, and that even though the family has declined to allow the child to return to their care post discharge, reunification services must still be offered for 12-18 months. The "plan of services" sections did not document all services provided or the frequency of the services.

Of the seven (7) Initial NSPs reviewed, all seven (7) were not comprehensive in that the "Outcome Goals" section did not meet the SMART Goals guidelines. However, it is noteworthy to mention that the Initial NSPs reviewed from TYS-

Apple Valley and TYS-Yucaipa have significantly improved since the previous monitoring year. For the first NSP file reviewed from TYS-El Monte, the children's Outcome Goals lacked information regarding how treatment services and frequency of services were being provided in the "Plan and Services" section and the reporting on the Outcome Goal for the "Independent Living Services" was incorrectly documented and lacked the required information needed. For the second reviewed from TYS-El Monte, the Outcome Goal for "Permanency Planning" and "Psychological/Developmental/Behavior" should have already been established in the "Specific Goal" section by the 30th day of the Initial NSP report. The reporting on the Outcome Goal for the "Independent Living Services" was also incorrectly documented and lacked the required information needed.

For the third reviewed at TYS-El Monte, the child's Outcome Goals lacked information regarding how treatment services and the frequency of services were being provided in the "Plan and Services" section; and the reporting of the Outcome Goal for the "Independent Living Services" was incorrectly documented, lacking the required information needed. The "Specific Goal" sections should have already been established for the Outcome Goals #3 and #4 by the 30th day of the Initial NSP report.

For the fourth reviewed from TYS-Yucaipa, Outcome Goals #4 and #5 lacked information required regarding the frequency of services the child was being provided with on the "Plan and Services" section. For the fifth reviewed from TYS-Yucaipa, the Outcome Goals for #3, #4 and #5 also lacked information regarding the frequency of services the child was being provided with on the "Plan and Services" section.

For the sixth and seventh reviewed from TYS-Apple Valley, both the "Method" sections for Outcome Goals #1 and #2, were incorrectly documented and lacked the required information needed. The "Plan and Services" sections for Outcome Goal #5 lacked information regarding how treatment services and frequency of services were being provided to the child. Therefore, all three (3) Trinity sites were not in compliance with the element, "The Initial NSP was completed accurately and on time?"

Of the six (6) Updated NSPs reviewed, two (2) files from Trinity-Yucaipa continued to have the incorrect dates for when the children were enrolled in school. This is the same issue, as with the Initial NSPs, where the date was incorrectly documented by the therapist; however, the children were enrolled in school within three (3) days of their arrival to TYS-Yucaipa.

Of the six (6) Updated NSPs reviewed, all six continued to lack comprehensiveness in that the Outcome Goals section did not meet the SMART Goals guidelines. However, it noteworthy to mention that the Updated NSPs

reviewed from TYS-Apple Valley and TYS-Yucaipa have significantly improved since the previous monitoring year. For the first Updated NSP reviewed from TYS-El Monte, the children's Outcome Goals continued to lack information regarding how treatment services and the frequency of services were being provided in the "Plan and Services" section; and the reporting on the Outcome Goal for the "Independent Living Services" was incorrectly documented, lacking the required information needed. For the second file reviewed from Trinity-El Monte, the child's Outcome Goals continued to lack information regarding how treatment services and the frequency of services were being provided in the "Plan and Services" section. The reporting on the Outcome Goal for "Independent Living Services" was incorrectly documented and lacked the required information needed. The "Specific Goal" sections still had not been established for Outcome Goal #3, an indication that the Outcome Goals were not properly reviewed by the clinicians.

For the third reviewed from TYS-Yucaipa, Outcome Goals #4 and #5 continued to lack information regarding the frequency of services the child was being provided with on the "Plan and Services" section. For the fourth reviewed from TYS-Yucaipa, the Outcome Goals #3, #4 and #5 also continued to lack information regarding the frequency of services the child was being provided with on the "Plan and Services" section.

For the fifth and sixth reviewed from TYS-Apple Valley, both the "Method" sections for Outcome Goals #1 and #2, continued to be incorrectly documented and lacked the required information needed. The "Plan and Services" sections for Outcome Goal #5, also continued to lack information regarding how the treatment services and frequency of services were being provided to the child. Therefore, all three (3) Trinity sites were not in compliance with the element, "The Updated NSPs were completed accurately and on time?"

Recommendation

Trinity Youth Services management shall ensure that:

1. The Initial NSP was completed accurately and on time.

2. The Updated NSPs were completed accurately and on time.

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

PPQA/GHM's last compliance report dated December 1, 2016, identified seven (7) recommendations.

Results

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

- The employees undergo routine "Pro-Act" or "Emergency Intervention" training to avoid future reoccurrences.

- The large crack on the wall in the training room at Trinity-Apple Valley was repaired. The cracked faucet handle and damaged faucet at Trinity-Apple Valley was replaced. The broken mirror frame and missing shop light lens cover at Trinity-Apple Valley was repaired and replaced.

- The cracked right faucet handle at Trinity-El Monte was replaced.

- All necessary efforts were made to ensure that the children are progressing towards meeting their Case Plan Goals.

- All necessary efforts were made to ensure that the Children's Academic or Attendance Increased.

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

- The two (2) rear tires with low thread wear at Trinity-Apple Valley are replaced. Although, they did replace the rear tires, this year the front tires have low thread wear and all tires are to be maintained together.

- All Initial and Updated NSPs are comprehensive and meet the SMART Goals requirement.

MOST RECENT FISCAL REVIEW CONDUCTED BY THE AUDITOR-CONTROLLER

A fiscal review of Trinity Youth Services was completed for the 2015-2016, fiscal period by the Department of Auditor Controller; however, the report has not been posted.

TRINITY®
Youth Services

Mission Office
Foster Care • Residential Services

COA

Date: June 2, 2017

To: Probation Department's Group Home Monitor Unit
Attention: Deputy Probation Officer Leng Lim

From: Trinity Youth Services – Apple Valley, El Monte, Yucaipa

Re: Corrective Action Plan 2016 – 2017, Probation Monitor Review

DPO Lim,

The Los Angeles County Probation Department has completed their audit review for the fiscal year 2016 – 2017 for the Trinity Youth Services campuses. We fully acknowledge and are in agreement with the deficiencies you noted during your audit of the campuses. We appreciate you meeting with the Trinity campus directors and our clinical team to address the deficiencies cited.

Attached are Trinity – Apple Valley, El Monte, and Yucaipa's Corrective Action Plan for fiscal year 2016 – 2017 to address the areas of deficiency.

Thank you for your constructive feedback. Trinity Youth Services strives to provide quality programs for youth on probation. We will continue working to ensure that we are meeting or exceeding the high standards set forth by the Los Angeles County Probation Department.

Please contact Ms. Tamoush (Apple Valley) at (760) 247-9840 or Gil Quinbar (Yucaipa, El Monte) at (909) 797-0114, if you have any questions.

Respectfully,

Trinity Youth Services
Campus Directors

Trinity Youth Services
Trinity-Apple Valley Site
10755 Apple Valley Road
License Number: 366401747
Rate Classification Level: 12

I. Licensure/Contract Requirements:

Vehicle Maintained in Good Repair:

Findings:
Two vehicles (License plate #: 7FTH712 and 7FTH715) have loose carpeting that was not intact in the first passenger row.

Cause:
The carpeting began pulling up from the floor of the vans in the first passenger row due to continuous use.

Corrective Action Plan:
On 3/17/17, we secured the carpeting to the floor of the vans with new Velcro. In addition, we secured factory floor mats on top of the carpeting. As of 6/1/17, both vans were returned to the leasing agency and replaced with two 2017 Dodge Grand Caravans.

Quality Assurance Plan:
Maintenance staff will continue to inspect the vans, including carpeting, on a weekly basis. A new column has been added on the vehicle inspection checklist to indicate the condition of the carpet. Vehicle inspection checklists will continue to be submitted to our Mission office and the Campus Director or the Assistant Campus Director for review.

To ensure compliance, the Campus Director or the Assistant Campus Director will conduct weekly independent reviews of the vans. Any deficiencies observed that were not noted by the maintenance staff will result in disciplinary action.

II. Facility and Environment:

1. Common Areas Maintained:

Findings:
Bruins Dorm – Presence of mold on the shower walls and floor in Restroom C. Aztec Dorm – Presence of mold on the old caulking on the shower pan in Restroom C.

Cause:
The Campus Director did not detect these maintenance issues during a weekly walk of the campus with the maintenance staff. This was due to an oversight. While the restrooms were

cleaned on a regular basis, both required the purchase of specialized cleaners and caulking in order to correct the problems.

Corrective Action Plan:
The deficiencies noted in the findings were all repaired or replaced on 3/17/17. We used industrial-strength mold and mildew cleaner to clean the shower and remove the mold in Bruins Dorm, Restroom C. We removed the old caulking and re-caulked the shower with mold- and mildew-resistant caulking in Aztecs Dorm, Restroom C.

Quality Assurance Plan:
A quality assurance plan is already in place whereby the dorm supervisors complete maintenance checklists. The Campus Director will continue to review checklists, conduct weekly walkthroughs with maintenance staff, and complete maintenance checklists on a weekly basis. In addition, our housekeeping staff has been given the additional duty of spending one day a week deep-cleaning the restrooms. The housekeeping staff will notify the Campus Director or Assistant Campus Director about any mold or mildew problems. In addition, the tile shower in Bruins Dorm, Restroom C will be replaced with a fiberglass insert by the end of the year.

To ensure compliance, the Campus Director or the Assistant Campus Director will conduct weekly independent inspections of the restrooms. Any deficiencies observed that were not noted by the dorm supervisors will result in disciplinary action.

III. Maintenance of Required Documentation and Services Delivery

1. Findings:
Two of Trinity Apple Valley's Initial NSP files reviewed were not comprehensive as the Outcome Goal sections did not meet the SMART Goals guidelines. Both the "Method" sections for Outcome Goals #1 and #2 were incorrectly documented. The "Plan and Services" sections for Outcome Goal #5 lacked information regarding how treatment services and the frequency of services are being provided to the child.

Cause:
The therapist submitting the NSPs wrote SMART Goals that did not follow all of the guidelines. For the majority of the monitoring period, Trinity Apple Valley did not have a Clinical Coordinator and was actively attempting to fill the position. The Clinical Director from Trinity Yucaipa and the Campus Director were both attempting to oversee the clinical program at the Apple Valley campus. Both incorrectly determined the SMART goal guidelines were met. This is a staffing and training issue. Clarification was received regarding expectations for the correct documentation in this area.

Corrective Action Plan:
The monitor reviewed SMART Goals during his meeting with the Campus Directors, Clinical Coordinators, and Case Managers on 5/3/17. On 5/12/17, the staff responsible for writing NSPs and SMART goals received NSP and SMART Goal retraining, presented by the Case Manager using the monitoring review report and the LA County PowerPoint presentation on NSP/Quarterly Reports, which included information on SMART Goals. In addition, the Director

of Mental Health Services for Trinity Youth Services will conduct training on SMART Goal Guidelines for all staff involved in the development and review of SMART Goals on 6/20/17.

Quality Assurance Plan:
On 2/16/17, Trinity Apple Valley hired a full-time Case Manager and a full-time Clinical Coordinator. Moving forward, they will provide oversight on all of the NSPs. Once completed, the therapists will submit the NSPs to the Case Manager and Clinical Coordinator for review. The Case Manager and Clinical Coordinator will ensure that all NSPs meet the SMART Goals guidelines prior to submission to the DPO of record. An ongoing review of the NSP has been included in our campus PQI process. Every three months the Case Manager and Clinical Coordinator will review 25% of our NSPs. An audit tool specific to the NSP is being developed with input from members of the Treatment Team. The Case Manager and Clinical Coordinator will conduct quarterly audits to ensure compliance. All staff involved in writing SMART goals that are identified as deficient will receive retraining by the Case Manager and/or Clinical Coordinator. In addition, a template for the NSP was developed for the therapists to use as a reference. This template provides an explanation to how each field is to be filled out. Sample treatment goals that meet the SMART goal guidelines are provided, as well.

To ensure compliance, the Campus Director or Assistant Campus Director will conduct random checks of the NSPs to confirm that the Therapist, Case Manager, and Clinical Coordinator are following the SMART goal guidelines. If it is determined that the therapist(s) is submitting NSPs and not following SMART goal guidelines, disciplinary action will occur. If it is determined that the Case Manager or Clinical Coordinator are approving NSPs that are not following the SMART goal guidelines, disciplinary action will occur.

2. Findings:
Two of Trinity Apple Valley's Updated NSP files reviewed were not comprehensive as the Outcome Goal sections did not meet the SMART Goals guidelines. The "Method" sections for Outcome Goals #1 and #2 continued to be incorrectly documented. The "Plan and Services" sections for Outcome Goal #5 continued to lack information regarding how treatment services and the frequency of services are being provided to the child.

Cause:
The therapist submitting the NSPs wrote SMART Goals that did not follow all of the guidelines. During the monitoring period, Trinity Apple Valley did not have a Clinical Coordinator and was in the midst of the hiring process. The Clinical Director from Trinity Yucaipa and the Campus Director were both attempting to oversee the clinical program at the Apple Valley campus. Both incorrectly determined the SMART goal guidelines were met. This is a staffing and training issue. Clarification was received regarding expectations for the correct documentation in this area.

Corrective Action Plan:
The monitor reviewed SMART Goals during his meeting with the Campus Directors, Clinical Coordinators, and Case Managers on 5/3/17. On 5/12/17, the staff responsible for writing NSPs and SMART goals received NSP and SMART Goal retraining, presented by the Case Manager using the monitoring review report and the LA County PowerPoint presentation on

NSP/Quarterly Reports, which included information on SMART Goals. In addition, the Director of Mental Health Services for Trinity Youth Services will conduct training on SMART Goal Guidelines for all staff involved in the development and review of SMART Goals on 6/20/17.

Quality Assurance Plan:
On 2/16/17, Trinity Apple Valley hired a full-time Case Manager and a full-time Clinical Coordinator. Moving forward, they will provide oversight on all of the NSPs. Once completed, the therapists will submit the NSPs to the Case Manager and Clinical Coordinator for review. The Case Manager and Clinical Coordinator will ensure that all NSPs meet the SMART Goals guidelines prior to submission to the DPO of record. An ongoing review of the NSP has been included in our campus PQI process. Every three months the Case Manager, Clinical Coordinator and Campus Director will review 25% of our NSPs. An audit tool specific to the NSP is being developed with input from members of the Treatment Team. The Case Manager, Clinical Coordinator, and Campus Director will conduct quarterly audits to ensure compliance. All staff involved in writing SMART goals that are identified as deficient will receive retraining by the Case Manager and/or Clinical Coordinator. In addition, a template for the Needs and Services Plan was developed for the therapists to use as a reference. This template provides an explanation to how each field is to be filled out. Sample treatment goals that meet the SMART goal guidelines are provided, as well.

To ensure compliance, the Campus Director or Assistant Campus Director will conduct random checks of the NSPs to confirm that the Therapist, Case Manager, and Clinical Coordinator are following the SMART goal guidelines. If it is determined that the therapist(s) is submitting NSPs and not following SMART goal guidelines, disciplinary action will occur. If it is determined that the Case Manager or Clinical Coordinator are approving NSPs that are not following the SMART goal guidelines, disciplinary action will occur.

The lack of a clear, consistent understanding of the SMART goal guidelines by all staff involved in the review of the NSPs has led to the continuing failure to ensure that the outcome goals are written correctly. Our current Quality Assurance Plan was unsuccessful due to our ineffective internal audit process. We are committed to provide continuous training, and monitoring of the NSP's to ensure they meet the SMART goal guidelines. We made adjustments to our Quality Assurance Plan based on the feedback we receive from each LA County monitoring visit, and have made improvements. Our recent hiring of a Case Manager and Clinical Coordinator will provide the additional oversight needed to guarantee accurate completion of the NSP.

E Tamoush

Elizabeth Tamoush, Campus Director

6/13/17

Date

Trinity Youth Services
El Monte Site
11057 Basey Street
El Monte, CA 91731
License Number: 191591941
Rate Classification Level: 12

CCL Complaints on Safety/Plant Deficiencies

Findings:
Community Care Licensing (CCL) reported a Substantiated Complaint on December 14, 2016, for Reporting Requirements regarding late reporting of a Special Incident Report (SIR) involving a probation youth that occurred on October 23, 2016, and the agency submitted the SIR on November 3, 2016, via the Incident Tracking System (i-Track) 10 days later.

Cause:
The previous campus director failed to ensure that a Special Incident Report (SIR) was reported in a timely manner.

Corrective Action Plan:
Staff were retrained on November 16, 2016, and reminded of the facility's reporting obligation and the need to be timely in reporting incidents.

Quality Assurance Plan:
All staff receives ongoing training on the requirements of writing and submitting Incident Reports (IR) that occur at the facility. IR's are read every morning by the Campus Director and the Assistant Campus Director. Any incident reports that require a SIR submission to CCL or the county monitor(s) are identified and reported by the Campus Director or a designee that same day. If an incident occurs after business hours, it will be reported the next business day. Any serious incidents occurring over the weekend are brought to the attention of the Campus Director and Assistant Campus Director. The Campus Director will ensure all SIR's are submitted in a timely manner. In the event of the director's absence, the Assistant Director will ensure all SIR's are submitted in a timely manner.

To ensure compliance, the Campus Director or Assistant Campus Director will conduct routine checks of the dorm logs to ensure that IR's have been submitted to the Campus Director and Assistant Campus Director. These checks will ensure that SIR's are submitted to CCL or the county monitor(s) in a timely manner. Any failure by staff to report IR's will result in disciplinary actions.

III. Maintenance of Required Documentation and Service Delivery:

1. **Findings:**
   Outcome Goals were not Specific, Measurable, and Attainable as required by SMART Goal guideline.

   The first file reviewed lacked information regarding treatment service being provided and the frequency of the services in the "Plan and Services" sections and the reporting on the Independent Living Skills Outcome Goal was incorrectly documented.

   Cause:
   The "Plan and Services" sections only documented one service and did not specifically state the frequency of the service being provided due to our misinterpretation of the correct way of documenting goals and services on the NSP.

   Regarding the Independent Skills Outcome Goal, the goal was designed based on whether the youths were required to complete restitution and/or community services. The treatment team determined that the youths would be able to move towards maintaining Independent Living Skills based on their development of accountability and responsibility for their obligations. For those struggling to socialize appropriately, maintain healthy boundaries, and demonstrating respect towards others, the treatment team had hoped that working on this type of goal was specific to struggles that inhibited the youths' ability to independently interact with others, coexist with others, and develop respectful relationships with others.

   Corrective Action Plan:
   The monitor reviewed SMART Goals during his meeting with the Campus Directors, Clinical Director, Clinical Coordinators, and Case Managers on 5/3/17. The staff responsible for writing NSPs and SMART goals will receive NSP and SMART Goal training by the Director of Mental Health on 06/22/17.

   A Case Manager was hired on 04/24/2017 to assist in the completion and review of the Needs and Services Plan. The Case Manager started NSP training on 04/26/2017.She is currently going through ongoing training on the NSP guidelines and regulations. The Case Manager will collaborate with the treatment team to ensure that a SMART goal is appropriately documented for youth 17 ½ years or older. For youth younger than this, Independent Living Skills goals are not required. Each outcome goal developed will outline all the services provided relevant to the attainment of that particular goal and will appropriately document who is assisting youths to progress towards accomplishing and modifying the specific goals and objectives regarding Independent Living Skills.

Quality Assurance Plan:
A Case Manager was hired on 04/24/2017 to assist with the QA process for monitoring accurate reporting and timely submission of the Needs and Services Plans (NSP). A template for the NSP's was developed for the therapists and Case Manager to use as a reference. This template provides an explanation as to how each field is filled out and sample treatment goals that meet the SMART goal guidelines are provided as well. Once completed the NSP will submit the NSP to the Case Manager and Clinical Coordinator for approval.
An ongoing review of the NSP has been included in our campus PQI process. Every three months the Clinical Coordinator and Assistant Director will review 25% of our NSP's. An audit tool specific to the NSP is being developed with input from members of the Treatment Team.

To ensure compliance the Campus Director or Assistant Campus Director will conduct random checks of the NSP's to confirm that the Therapist, Case Manager, and the Clinical Coordinator are following SMART goal guidelines. If it is determined that a therapist(s) is submitting NSP's and not following SMART goals guidelines, disciplinary actions will occur. If it is determined that the Case Worker or Clinical Coordinator are approving NSP's that are not following SMART goals guidelines, then disciplinary action will occur.

2. **Findings:**
The second file reviewed indicated the "Specific Goal" sections should have already been established for the Permanency Planning, and Psychological/Development/Behavior Outcome Goals. The reporting on the ILS Outcomes Goal was incorrect.

Cause:
Treatment team followed the DMH regulations regarding the establishment of goals. Treatment team failed to separate the goal establishment between DMH and probation requirements.

Corrective Action Plan:
Goal development begins as soon as the youth is placed in the treatment program. The therapists will complete their assessments within 30 days of youth's arrival to the program. The treatment team will also utilize the initial child and family team meeting to establish goals that the youth has identified.

Quality Assurance Plan:
All efforts will be made to ensure that a child and family team meeting is held within the first fourteen days of youth's placement in the treatment program wherein the treatment team, including the youth, can collaborate on goal development. The Case Manager will ensure that a developed and established goal is documented on the Needs and Services Plan. The Clinical Coordinator will review that the goal is established and documented per report.

A Case Manager was hired on 04/24/2017 to assist with the QA process for monitoring accurate reporting and timely submission of the Needs and Services Plans (NSP). A template for the NSP's was developed for the therapists and the Case Manager to use as a reference. This template provides an explanation as to how each field is filled out and sample treatment goals that meet the SMART goal guidelines are provided as well. Once completed the therapists will submit the NSP to the Case Manager and Clinical Coordinator for approval.

An ongoing review of the NSP has been included in our campus PQI process. Every three months the Clinical Coordinator and Assistant Director will review 25% of our NSP's. An audit tool specific to the NSP is being developed with input from members of the Treatment Team.

To ensure compliance the Campus Director or Assistant Campus Director will conduct random checks of the NSP's to confirm that the Therapist, Case Manager, and the Clinical Coordinator are following SMART goal guidelines. If it is determined that a therapist(s) is submitting NSP's and not following SMART goals guidelines, disciplinary actions will occur. If it is determined that the Case Worker or Clinical Coordinator are approving NSP's that are not following SMART goals guidelines, then disciplinary action will occur.

3. **Findings:**
The third file reviewed indicated the child's Case Plan Goal should be checked off for Family Reunification (F/R) instead of PPLA/Transition as there was no information that F/R was already established for one year. File lacked information regarding how treatment services are being provided and frequency of services in the "Plan and Services" section. ILS Outcome Goal was incorrect, and the "Specific Goal" sections should have already been established for the Outcome Goals #3 and 4.

Cause:
Our error in misunderstanding the correct response for this section. The 3rd report is based on youth that has been on probation, and the family has declined to allow the youth to return to their care post discharge. The "Plan and Services" sections did not document all services provided and did not specifically state the frequency of the services being provided due to our misinterpretation of the correct way of documenting goals and services.

Corrective Action Plan:
A documentation training for the staff will be conducted by Trinity's Director of Mental Health. The training is scheduled for 6/22/2017. The training will review the family reunification guidelines. To ensure accurate reporting of family reunification, we will review the family's progress toward family reunification at the initial child and family team meetings and request documentation from youth's previous placement of attempts made toward family reunification. If

family reunification has not been established for one year, we will continue to document all efforts to engage the family toward family reunification, including collateral sessions and phone calls made by the treatment team to family members.

Quality Assurance Plan:
Case Manager will ensure that "family reunification" is always marked as the Case Plan Goal if family reunification has not been established for one year. The Clinical Coordinator will review the report to ensure that the correct field is marked.

A Case Manager was hired on 04/24/2017 to assist with the QA process for monitoring accurate reporting and timely submission of the Needs and Services Plans (NSP). A template for the NSP's was developed for the therapists and Case Manager to use as a reference. This template provides an explanation as to how each field is filled out and sample treatment goals that meet the SMART goal guidelines are provided as well. Once completed the therapists will submit the NSP to the Case Manager and Clinical Coordinator for approval.

An ongoing review of the NSP has been included in our campus PQI process. Every three months the Clinical Coordinator and Assistant Director will review 25% of our NSP's. An audit tool specific to the NSP is being developed with input from members of the Treatment Team.

To ensure compliance the Campus Director or Assistant Campus Director will conduct random checks of the NSP's to confirm that the Therapist, Case Manager, and the Clinical Coordinator are following SMART goal guidelines. If it is determined that a therapist(s) is submitting NSP's and not following SMART goals guidelines, disciplinary actions will occur. If it is determined that the Case Worker or Clinical Coordinator are approving NSP's that are not following SMART goals guidelines, then disciplinary action will occur.

2. <u>Development of Timely, Comprehensive Updated NSPs with Child's Participation:</u>

1. Findings:
Two files reviewed indicated Outcome Goals were not Specific, Measurable, and Attainable as required by the SMART Goals guidelines.
The first file reviewed lacked information regarding treatment service being provided and the frequency of the services in the "Plan and Services" sections and the reporting on the Independent Living Skills Outcome Goal was incorrect.

Cause:

Treatment team followed the DMH regulations regarding the establishment of goals. Treatment team failed to separate the goal establishment between DMH and probation requirements.

Corrective Action Plan:
The treatment team will ensure that a goal is established per youth upon their placement at the facility. The goal will specify the specific type of treatment utilized and frequency of services provided to the youth. A specific ILP/S goal will only be developed for youth 17 ½ years and older focusing on the client's daily living skills and practices (personal hygiene, maintaining schedule, maintaining a clean living environment, cleaning laundry, cohesively coexisting with others in living environment). For those under 17 ½, information will be provided on quarterly basis of dorm staff assisting youth with building these skills, attending workshops, and completing ILP/S assignments.
The treatment team will ensure that each youth is progressing towards ILP/S goals and developing skills associated with this area. Case Manager will ensure that the information and/or goal is appropriately documented. Clinical Coordinator will review goals to ensure quality and necessity of documented effort.

Quality Assurance Plan:
A Case Manager was hired on 04/24/2017 to assist with the QA process for monitoring accurate reporting and timely submission of the Needs and Services Plans (NSP). A template for the NSP's was developed for the therapists and Case Manager to use as a reference. This template provides an explanation as to how each field is filled out and sample treatment goals that meet the SMART goal guidelines are provided as well. Once completed the therapists will submit the NSP to the Case Manager and Clinical Coordinator for approval.

An ongoing review of the NSP has been included in our campus PQI process. Every three months the Clinical Coordinator and Assistant Director will review 25% of our NSP's. An audit tool specific to the NSP is being developed with input from members of the Treatment Team.

To ensure compliance the Campus Director or Assistant Campus Director will conduct random checks of the NSP's to confirm that the Therapist, Case Manager, and the Clinical Coordinator are following SMART goal guidelines. If it is determined that a therapist(s) is submitting NSP's and not following SMART goals guidelines, disciplinary actions will occur. If it is determined that the Case Worker or Clinical Coordinator are approving NSP's that are not following SMART goals guidelines, then disciplinary action will occur.

2. Findings:

The second file reviewed lacked information regarding how treatment services are being provided and the frequency of services in the "Plan and Services" section. The "Method" section was incorrectly documented in accordance to the SMART Goals Guidelines. The reporting on the ILS Outcome Goal continued to be incorrect, and the "Specific Goal" section should have been established for Outcome Goal #3.

Cause:
A blanket statement was documented, and information was not specific enough regarding the youth. The "Plan and Services" and "Method" sections were incorrectly documented due to our misinterpretation of the correct way of documenting goals and services on the NSP.

Corrective Action Plan:
A Case Manager was hired on 04/24/2017 to assist in the completion and review of the Needs and Services Plan. The Case Manager started her NSP training on 04/26/2017. She is currently going through training on the NSP guidelines and regulations. Trinity's Mental Health Director will conduct documentation training for the staff on 6-22-2017. He will go over each section of the Needs and Services Plan and will provide training to ensure that all goals developed will meet SMART goal guidelines. The Case Manager will collaborate with the treatment team to ensure that a SMART goal is appropriately documented for youth 17 ½ years or older. For youth younger than this, ILP/S goals are not required. Each outcome goal developed will outline all the services provided relevant to the attainment of that particular goal and will appropriately document who is assisting youths to progress towards accomplishing and/or modifying the specific goals and objectives. The frequency of the services and a systematic plan to help the youth achieve the goal will be documented moving forward.

Quality Assurance Plan:
A Case Manager was hired on 04/24/2017 to assist with the QA process for monitoring accurate reporting and timely submission of the Needs and Services Plans (NSP). A template for the NSP's was developed for the therapists and Case Manager to use as a reference. This template provides an explanation as to how each field is filled out and sample treatment goals that meet the SMART goal guidelines are provided as well. Once completed the therapists will submit the NSP to the Case Manager and Clinical Coordinator for approval.

An ongoing review of the NSP has been included in our campus PQI process. Every three months the Clinical Coordinator and Assistant Director will review 25% of our NSP's. An audit tool specific to the NSP is being developed with input from members of the Treatment Team.

To ensure compliance the Campus Director or Assistant Campus Director will conduct random checks of the NSP's to confirm that the Therapist, Case Manager, and the Clinical Coordinator are following SMART goal guidelines. If it is determined that a therapist(s) is submitting NSP's and not following SMART goals guidelines, disciplinary actions will occur. If it is determined that the Case Worker or Clinical Coordinator are approving NSP's that are not following SMART goals guidelines, then disciplinary action will occur.

The lack of a clear, consistent understanding of the SMART goal guidelines by all staff involved in the review of the NSP's has led to the continuing failure to ensure that the outcome goals are written correctly. Our current Quality Assurance Plan was unsuccessful due to our ineffective internal audit process. We are committed to providing continuous training, and monitoring of the NSP's to ensure they meet the SMART goal guidelines. We made adjustments to our QA plan based on the feedback we receive from each LA County monitoring visit and have made improvements. Our recent hiring of a case manager will provide the additional oversight needed to guarantee accurate completion of the NSP.

Gil Quinbar, Interim Campus Director

Trinity Youth Services
Trinity-Yucaipa
10776 Fremont St.
Yucaipa, CA 92399
License Number: 360900416
Rate Classification Level: 12

1. **Licensure/Contract Requirement:**

Findings:
Both front tires have low tread wear on vehicle 7LAB318. The front right tire has low tread wear on vehicle 7RNY806.

Cause:
Both vehicles were scheduled for maintenance prior to the audit which was conducted on March 21, 2017. However, both vans were not serviced before the audit. Additionally, both vans were not grounded at the time of the audit review.

Corrective Action Plan:
During the Maintenance appointment on March 22, 2017, vehicle 7RNY806 had all four tires replaced. On March 23, 2017, vehicle 7LAB318 had all four tires replaced.

Quality Assurance Plan:
Maintenance staff will continue to complete a weekly vehicle maintenance checklist. The maintenance checklist is submitted to our Mission Office and the Campus Director for review. Any vehicles that have visible low tread wear will be grounded until the vehicle(s) have been serviced

To ensure compliance, the Campus Director or Assistant Campus Director will conduct their own weekly check of the vehicles. If any deficiencies are observed that was not noted on the weekly maintenance staff checklist, then disciplinary action will occur for the maintenance staff.

CCL Complaints on Safety/Plant Deficiencies

Findings:
Community Care Licensing (CCL) reported a Substantiated Compliant on December 20, 2016, for Personal Rights Violation regarding Enema being administered by unskilled professional, a Certified Nursing Assistant (CNA). Enemas can only be administered by a Registered Nurse (RN) or a physician. The agency was not cited; however, a Corrective Action Plan was submitted to CCL to address the deficiency and approved.

Cause:
The CNA administered an enema at the request of the youth. However, Trinity Youth Services Program Statement does not indicate that administering this type of treatment is permitted.

Corrective Action Plan:
As per our accepted CAP to CCL, staff was trained December 22, 2017, on proper procedures on assistance with administration of medication. Staff will not administer enemas to any youth.

Quality Assurance Plan:
Any youth seeking assistance regarding help with the administering of an enema will be transported to a medical professional. All staff will continue to be trained on the proper approved procedures for medical treatment.

To ensure compliance, we will conduct ongoing medication training to comply with Trinity Youth Services Program Statement and CCL guidelines. Any staff violating this policy will be subject to disciplinary action.

II. Facility and Environment:

1. **Findings:**
Uneven, cracked concrete slab that lifted up over an inch located between the parking lot and basketball court.

Cause:
The maintenance staff, Campus Director or designee walks the campus weekly to identify maintenance issues. However, the lifted concrete slab was not noticed. This was an oversight.

Corrective Action Plan:
The uneven slab has been sanded down even with the rest of the concrete.

Quality Assurance Plan:
The maintenance staff will continue to do a weekly walk through of the campus to ensure the campus is free from any safety deficiencies. Additionally, members of the safety committee will continue to randomly walk the campus and will submit a work order request to address any facility/maintenance concerns that are identified.

To ensure compliance the Campus Director or Assistant Campus Director will conduct their own weekly check of the campus, if any deficiencies are observed that were not noted on the weekly maintenance checklist, then disciplinary action will occur for the maintenance staff.

III. Maintenance of Required Documentation and Service Delivery:

1. Development of Timely, Comprehensive Initial NSPs with Child's Participation:

Findings:
Incorrect School Enrollment Date.

Cause:
The school enrollment date was documented incorrectly by the therapist and oversight by our QA process. The youth was enrolled in school within three days of arrival to the program.

Corrective Action:
The Case Manager and Clinical Director conducted training on accurate reporting on the Needs and Services Plan on May 9th, 2017. The CCL standards for timeliness of youth enrollment were reviewed so that they are more acutely aware of the timeline for school enrollment. The therapists were then referred to the school section of the client file where they can obtain the school enrollment date.

Quality Assurance Plan:
A Case Manager was hired to assist with the QA process for monitoring accurate reporting and timely submission of the Needs and Services Plans (NSP). A template for the NSP's was developed for the therapists and Case Manager to use as a reference. This template provides an explanation as to how each field is filled out and sample treatment goals that meet the SMART goal guidelines are provided as well. Once completed the therapists will submit the NSP to the Case Manager and Clinical Director for approval.
An ongoing review of the NSP has been included in our campus PQI process. Every three months the Clinical Director and Assistant Director will review 25% of our NSP's. An audit tool specific to the NSP is being developed with input from members of the Treatment Team.

To ensure compliance the Campus Director or Assistant Campus Director will conduct random checks of the NSP's to confirm that the Therapist, Case Manager, and the Clinical Coordinator are following SMART goal guidelines. If it is determined that a therapist(s) is submitting NSP's and not following SMART goals guidelines, disciplinary actions will occur. If it is determined that the Case Worker or Clinical Coordinator are approving NSP's that are not following SMART goals guidelines, then disciplinary action will occur.

Findings: Frequency of Services

Cause:
The frequency of services was documented incorrectly. Instead of explicitly stating that the services were being provided to the youth "once a week," the report stated "weekly."

Corrective Action:
The Case Manager and Clinical Director conducted training on the accurate reporting of the NSP's on May 9th, 2017 to clarify that the reporting of the frequency of services need to be specific (e.g., once a week, once a month, every three months).

Quality Assurance Plan:
A Case Manager was hired on January 24, 2017, to assist with the QA process for monitoring accurate reporting and timely submission of the Needs and Services Plans (NSP). A template for the NSP's was developed for the therapists and the Case Manager to use as a reference. This template provides an explanation as to how each field is filled out and sample treatment goals that meet the SMART goal guidelines are provided as well. Once completed the therapists will submit the NSP to the Case Manager and Clinical Director for approval.
An ongoing review of the NSP has been included in our campus PQI process. Every three months the Clinical Director and Assistant Director will review 25% of our NSP's. An audit tool specific to the NSP is being developed with input from members of the Treatment Team.

To ensure compliance the Campus Director or Assistant Campus Director will conduct random checks of the NSP's to confirm that the Therapist, Case Manager, and the Clinical Coordinator are following SMART goal guidelines. If it is determined that a therapist(s) is submitting NSP's and not following SMART goals guidelines, disciplinary actions will occur. If it is determined that the Case Worker or Clinical Coordinator are approving NSP's that are not following SMART goals guidelines, then disciplinary action will occur.

The lack of a clear, consistent understanding of the SMART goal guidelines by all staff involved in the review of the NSP's has led to the continuing failure to ensure that the outcome goals are written correctly. Our current Quality Assurance Plan was unsuccessful due to our ineffective internal audit process. We are committed to providing continuous training, and monitoring of the NSP's to ensure they meet the SMART goal guidelines. We made adjustments to our QA plan based on the feedback we receive from each LA County monitoring visit and have made improvements. Our recent hiring of a case manager will provide the additional oversight needed to guarantee accurate completion of the NSP.

Gil Quinbar, Campus Director