COUNTY OF LOS ANGELES
PROBATION DEPARTMENT

9150 EAST IMPERIAL HIGHWAY
DOWNEY, CALIFORNIA 90242
(562) 940-2501

TERRI L. McDONALD
Chief Probation Officer

December 18, 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: **PHOENIX ACADEMY AT LAKE VIEW TERRACE GROUP HOME CONTRACT COMPLIANCE MONITORING REVIEW**

The Department of Probation, Placement Permanency & Quality Assurance (PPQA), Group Home Monitoring (GHM), conducted a review of Phoenix House at Lake View Terrace Group Home, operated by Phoenix Houses of Los Angeles, in January 2017. Phoenix House has one (1) site located in the Third Supervisorial District of Los Angeles County. They provide services to Los Angeles County Probation and Department of Children and Family Services (DCFS) foster children in addition to out-of-county placement agencies. According to the Phoenix House program statement, its purpose is to provide a residential program with a daily structured regimen to meet the rehabilitation, development, treatment, educational, recreational, and social needs of adolescents assessed with a primary substance use disorder and co-occurring emotional and mental health issues. The purpose of the program is to provide the children with the protective factors, skills, and opportunities to engage and reunite with their parents and families and become pro-social members of their community.

Phoenix House is a 110-bed site and is licensed to serve a capacity of 50 girls and 90 boys, 13-18 years of age. At the time of review, Phoenix House was serving 27 Los Angeles County children, 25 Probation and two (2) DCFS. For the sample size, the placed children's overall average length of placement was 3.6 months, and their average age was 16.8 years old.

Seven (7) children were randomly selected for the interview sample, five (5) Probation and two (2) DCFS. There were five (5) children in the sample who were prescribed

psychotropic medication, three (3) Probation and two (2) DCFS. Those cases were reviewed for timeliness of Psychotropic Medication Authorization and to confirm the required documentation of psychiatric monitoring. Additionally, three (3) discharged children's files, two (2) Probation and one (1) DCFS, were reviewed for 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 child interviews, all seven (7) children reported feeling safe at Phoenix House, and being provided with good care. However, four (4) children reported at least some level of dissatisfaction with the quality of services. Their concerns were that consequences and disciplinary action were not fairly implemented. Three (3) children reported that there was a lack of extracurricular and socially enriching activities provided. In addition, three (3) children reported that they were not always treated with respect and dignity because certain staff members belittled them and used profanity towards them. Phoenix House was in compliance with one (1) of the 10 areas of our Contract Compliance Review: "Health and Medical Needs".

PPQA/GHM noted deficiencies in nine (9) of the 10 areas, with 26 deficient elements, out of 76 specific elements within the 10 areas. The same deficiencies from the last review period were in five (5) of the 10 areas, "Facility and Environment", "Maintenance of Required Documentation and Service Delivery", "Personal Rights and Social/Emotional Well Being", "Discharged Children" and "Personnel Records".

Based on child and staff files and agency log reviews, the agency had notable deficiencies in all areas. In the area of "Licensure/Contract Requirements", they were deficient due to vehicle maintenance logs and proof of registration not properly maintained or were missing. Weekly allowance logs and monthly clothing logs were also inaccurate and missing dates of payments and balances. Additionally, Special Incident Reports were not maintained in the child's files or properly reported via the iTrack system. In the area of "Facility and Environment", Phoenix House needed to ensure that children's bedrooms were in good repair. During last year's review the agency was deficient in this area due to a lack of properly functioning furniture, excessive graffiti, and improperly functioning restroom amenities in children's bedrooms.

In the area of "Maintenance of Required Documentation and Service Delivery", last year Phoenix House had deficiencies due to missing Needs and Services Plan (NSP) signatures of approval from Deputy Probation Officers/Clinical Social Workers, NSP goals that were either unclear or improperly developed, missing therapeutic services documentation, improperly developed concurrent case plan goals, and in general, NSPs that were not accurately completed. The same issues remained this year in that the NSPs were not in order and were missing vital information on the progress of children's programs (i.e. inaccurate goals, late or missing signatures of participation, lacking clear case plans

and concurrent case plans, etc.). In the area of "Educational Workforce and Readiness", one (1) child did not have proof of being enrolled in school within three (3) days.

In the area of "Psychotropic Medication", children's court documentation was not in order and at least two (2) children had psychotropic medication information that conflicted with information provided in the children's NSPs, such as approved dosages and prescribed medication. In the area of "Personal Rights and Social/Emotional Well Being", the agency was out of compliance in nine (9) of the 10 elements in this section, which included some of the children reporting that the group home did not use a fair rewards and discipline system and that the agency did not provide socially enriching extracurricular activities. In the area of "Personal Needs/Survival and Economic Well-Being", two (2) children indicated that they are not provided with youth development services/daily living services.

During last year's review, Phoenix House was also found deficient in the area of "Discharged Children" due to one (1) of the sampled children not being discharged in accordance with their permanency plan due to a "7-day" removal request. Finally, in the area of "Personnel Records", last year Phoenix House failed to ensure that the sampled staff had all required trainings updated in accordance with Title 22 standards, and this year, staff file reviews revealed that some of the staff was missing information from their files such as proof of driver's license and proof of initial and ongoing training.

REVIEW OF REPORT

On March 2, 2017, Probation PPQA Monitor Armando Juarez held an Exit Conference with the Phoenix House LVT Program Director, Carol-Ann Scott, Quality Assurance Director, Sakineh Salmanpour, Human Resources Assistant Gabriela Robinson, and Unit Managers Olga Sykes and Chyra Martin. Program Director Scott agreed with the review findings and recommendations and was receptive to implementing systemic changes to improve their compliance with regulatory standards, as well as address the noted deficiencies in a Corrective Action Plan (CAP).

Phoenix House 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: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
Chinling Chen, Sr. Program Director
Errol Small, Director of Residential Services

PHOENIX ACADEMY AT LAKE VIEW TERRACE GROUP HOME
CONTRACT COMPLIANCE MONITORING REVIEW SUMMARY

License #: 191222731
Rate Classification Level: 12

	Contract Compliance Monitoring Review	Findings: January 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. Full Compliance
	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. Improvement Needed
	8. SIRs documented in the NSPs and case files being properly reported via the I-track system.	8. Improvement Needed
II	**Facility and Environment** (5 Elements)	
	1. The exterior and the grounds of the Group Home are well maintained.	1. Full Compliance
	2. Common quarters are well maintained.	2. Improvement Needed
	3. Children's bedrooms are well maintained.	3. Improvement Needed
	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.	Improvement Needed (ALL)
	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).	

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.	1. Improvement Needed 2. Full Compliance 3. Full Compliance
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.	1. Improvement Needed 2. Full Compliance
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. 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.	1. Full Compliance 2. Improvement Needed 3. Full Compliance 4. Full Compliance 5. Improvement Needed 6. Improvement Needed 7. Full Compliance 8. Full Compliance 9. Improvement Needed 10. Full Compliance 11. Improvement Needed

	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.	12. Improvement Needed 13. Improvement Needed 14. Full Compliance 15. Improvement Needed 16. Full compliance 17. Full Compliance 18. Improvement Needed
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. 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.	1. Full Compliance 2. Full Compliance 3. Full Compliance 4. Full Compliance 5. Full Compliance 6. Improvement Needed 7. Full Compliance 8. Full Compliance 9. Full Compliance 10. Full Compliance 11. Full Compliance 12. Full Compliance 13. Full Compliance 14. Full Compliance 15. Not Applicable 16. Full Compliance

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.	1. Full Compliance 2. Improvement Needed 3. Not Applicable
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). 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.	1. Full Compliance 2. Full Compliance 3. Full Compliance 4. Full Compliance 5. Improvement Needed 6. Full Compliance 7. Improvement Needed 8. Full Compliance 9. Full Compliance 10. Full Compliance 11. Improvement Needed 12. Full Compliance 13. Improvement Needed 14. Not Applicable

PHOENIX ACADEMY AT LAKE VIEW TERRACE GROUP HOME
CONTRACT COMPLIANCE MONITORING REVIEW
FISCAL YEAR 2016-2017

SCOPE OF REVIEW

The purpose of this review was to assess Phoenix House's compliance with the County Contract and State regulations and include a review of the Phoenix House 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, five (5) Probation and two (2) DCFS, 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, two (2) Probation and two (2) DCFS, 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, three (3) discharged children's files, two (2) Probation and one (1) DCFS, were reviewed to assess Phoenix House's compliance with permanency efforts.

Five 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 nine (9) areas were out of compliance.

Licensure/Contract Requirements

Phoenix House was out of compliance with four (4) of the eight (8) elements in this section as follows:

- During inspection of the six (6) facility vehicles, two (2) were either missing the registration or had it misplaced. Phoenix House maintains a check-out system for vehicles in which staff are required to sign vehicles in and out every time they are used. As part of this check-out system, staff are to sign for the vehicle keys and the vehicle packet, which includes proof of insurance and registration. The packet for vehicle two (2) did not have current proof of registration. In addition, vehicle three (3) had the proof of registration misplaced in another vehicle's packet. It was ~~also~~ discovered that five (5) of the vehicles were ~~also~~ missing accurate and/or current maintenance logs to indicate that the agency provided regular maintenance service for each vehicle. As a result, Phoenix House was out of compliance with the element "Vehicles used to transport children are maintained in good repair".

- A review of the children's files revealed that five (5) of the seven (7) children did not have accurate weekly allowance logs. Of these files, all five (5) of them were missing at least one (1) weekly payment in their log books, and at least one (1) of them did not have accurate end-of-month balances. In addition, at least two (2) of these children were missing logs for entire monthly periods, making it unclear if the children have been receiving their required payments. As a result, Phoenix House was out of compliance with the element "Weekly allowance logs are accurately maintained".

- A review of the children's files also revealed that none of the children in the sample size had accurate monthly clothing allowance logs. Each of the seven (7) children was missing payment logs for at least one (1) of the placement months. In addition, at least four (4) of the children were missing logs for multiple months. As a result, Phoenix House was out of compliance with the element "Monthly clothing allowance logs are accurately maintained".

- A cross-reference of the children's files and NSPs revealed that Phoenix House was not properly documenting special incidents from the DCFS i-Track system in the children's NSPs. Four of the seven (7) children had incidents such as AWOLs, sexual behavior, and drug use documented in the iTrack system that was not being reported in the respective child's NSPs. In addition, one (1) of the children had three (3) AWOL incidents that were not documented in their quarterly NSPs. As a result, Phoenix House was out of compliance with the element "SIRs documented in the NSPs and case files are being properly reported via the I-Track system".

Recommendation

Phoenix House management shall ensure that:

1. All vehicles used to transport children have current proof of registration and insurance at all times and are in compliance with California vehicle code regulations and Title 22 standards. In addition, all facility vehicles used to transport children are to have accurate and current maintenance logs, indicating that they are legally safe to operate.

2. Children's weekly allowance logs are properly and accurately maintained so that it can be determined if children's weekly allowance payments and balances are in accordance with Title 22 and the County Contract.

3. Children's monthly clothing logs are properly and accurately maintained so that it can be determined if children's monthly clothing allowance payments and balances are in accordance with Title 22 and the County Contract.

4. All special incidents documented in the I-Track system are also documented in children's files and respective NSPs, and vice-versa, in order to maintain accurate record keeping and to maintain compliance with all reporting requirements.

Facility and Environment

An inspection of the interiors and exteriors of Phoenix House revealed some cosmetic deficiencies in the Common area and the Children's Bedrooms that required correction.

- While conducting the facility inspection, the Odyssey Unit was found to have a Fire extinguisher in the common area hallway that was not within the proper pressure range. As a result, Phoenix House was out of compliance with the element "Common quarters are well maintained".

- During the facility inspection, the following deficiencies were found in the children's bedrooms: Amethyst Unit—Room 43 restroom light was not working and the floorboard was loose. Room 60 had dresser drawers that were broken and not functioning properly. Odyssey Unit—Room 224 restroom toilet was not flushing properly and had a large graffiti piece behind the door. Room 225 and room 228 restroom shower handles were broken. Room 240 and room 245 both required doorstops behind the entrance door. The walls behind the entrance doors had holes from the door handle hitting the wall. Renaissance Unit—Room 501 also required a door stop due to entrance door handle hole in the wall. Room 506 restroom light cover was missing. As a result of these physical deficiencies, Phoenix House was out of compliance with the element "Children's bedrooms are well maintained".

Recommendation

Phoenix House management shall ensure that:

1. The fire extinguisher in the common area of the Odyssey Unit is replaced with a functioning extinguisher and that the agency implement a safety check system to ensure that all fire extinguishers throughout the facility are all current and properly working.

2. The aforementioned cited deficiencies in the children's bedroom areas that have not already been fixed, are corrected and repaired in a timely fashion and that Phoenix House implement a system to check bedrooms for safety and function.

Maintenance of Required Documentation and Service Delivery

Seven children's files were reviewed, and of those, all seven (7) had initial NSPs reviewed. However, only four (4) children were placed long enough to have Updated NSPs in their files reviewed.

Of the seven (7) children with initial NSPs reviewed, all seven (7) were completed in a timely manner. However, six (6) of the seven (7) were not accurately completed. Phoenix House was out of compliance with the element "The initial NSP was completed accurately and on time" based on the following:

- Two of the children had initial NSPs that did not have clear concurrent case plans identified. One of the concurrent plans indicated that the child was to have a planned permanency living arrangement (PPLA), but the comments section did not indicate with whom the child would be living with. The second child's initial NSP had the family finding efforts box checked off, but the comments section indicated that the child would be living with biological father. As a result, the concurrent case plans for both of these children were unclear.

- Three of the children had initial NSPs that did not have SMART goals established. All three (3) of these children had goals that were unclear, convoluted, and/or unmeasurable. In addition, one (1) of these children was missing a goal regarding established ILP needs.

- Six of the children had initial NSPs that were missing timely signatures of approval. Three of these had Group Home supervisor approval signatures that were late, two (2) of which were excessively late (71 and 53 days late), and one (1) had the preparer of the NSP sign seven (7) days late. Of these children's initial NSPs, two (2) were missing CSW/DPO signatures and did

not have efforts to obtain signatures documented. In addition, one (1) of these children had the CSW/DPO signature completed 13 days late. One of the children also signed the NSP 13 days late, and another child's initial NSP did not have the child's signature of participation. Finally, two (2) of these children's NSPs indicated family involvement in their program, but were missing parental signature of approval of NSP plan.

Of the four (4) children who had updated NSPs, all four (4) were completed in a timely manner. However, none of the four (4) were accurately completed. Phoenix House was out of compliance with the element "The updated NSP was completed accurately and on time" based on the following:

- One (1) of them had an updated NSP with an unclear case plan. The initial plan was for reunification with aunt; however, the updated NSP changed the plan to PPLA without explanation for the change. Three of the children also had updated NSPs that did not have clearly identified concurrent plans. The plans either had conflicting information within the NSPs or did not clarify why the concurrent plans were changed. In addition, two (2) of the other children's NSPs did not have updated concurrent case plans, making it difficult to identify feasibility of implementation.

- One of the children's updated NSP was missing proper updates in the visitation section. The visitation section did not indicate the progress of child's relationship with parents or grandparents or the level of their involvement in the child's program.

- Three of the children had updated NSPs that did not have SMART goals established. All three (3) of these children had goals that were unclear, convoluted, and/or unmeasurable. As a result, some of the children's goals were unclear if they were achieved, and other goals that were not achieved were not properly modified. Finally, two (2) of these children were missing additional goals. The first child's NSP indicated that he had anger management issues, and the second child also had established ILP needs, but goals for these issues were not created by the agency.

- None of the four (4) children with updated NSPs had all of the required signatures of approval. One of the children had the preparer of the NSP sign 10 days late. Another of the children also signed the NSP late by 14 days. Two of the children also had parental involvement in their programs; however, the parental signatures were missing from their updated NSPs. Three of the children also had the Group Home supervisor approval signatures that were late, one (1) of which was excessively late (32 days late).

Of the four (4) children who had updated NSPs, two (2) of the four (4) children's files revealed that Phoenix House did not properly document the program services that may or may not have been provided. Phoenix House was out of compliance with the element ""The Group Home provided children with counseling and other services" based on the following:

- The first child was missing documentation of educational services that were provided, if any. The NSPs indicated that the child was behind on school credits, but there was no documentation indicating if any tutoring or other services were being provided to assist the youth towards educational progress. In addition, this same child required ILP services, but there was no proof that these services were provided.

- The second child did not have any documentation of individual counseling, group counseling, family counseling, and/or other counseling services that may have been provided.

Recommendation

Phoenix House management shall ensure that:

1. All initial NSPs are completed accurately and on time. The NSPs are to: (1) Have clear concurrent case plans identified that are in accordance with the comments section as well as the narrative of the entire NSP. (2) Have SMART goals that are clear and concise and are in accordance with County standards. In addition, Phoenix House shall ensure that case-specific goals are established for all of the identified needs of each child. (3) Have all signatures of approval for all initial NSPs, including, but not limited to, the Phoenix House approving supervisor, the County Worker, the child, and the parents, when applicable. In addition, if County Worker signatures cannot be obtained in a timely manner, Phoenix House shall ensure that efforts to obtain signatures are documented and attached to the initial NSPs in compliance with the County Contract and standards.

2. All updated NSPs are completed accurately and on time. The NSPs are to: (1) Have clear case plans and concurrent case plans identified that are in accordance with the comments section as well as the narrative of the entire NSP. In addition, if any changes to either of the plans are made, clear and concise explanations shall be provided. (2) Have updated NSPs with the required updated information in the visitation section of the NSPs, including, but not limited to, the progress of children's relationships with important people such as parents and grandparents. (3) Have updated SMART goals that are clear and concise and are in accordance with County standards. This is also to include clear descriptions of goals that have been achieved and clear

modifications to goals that have not been achieved, including changes in Group Home efforts to assist the children in achieving these goals. In addition, Phoenix House shall ensure that case-specific goals are established for all of the identified needs of each child. (4) Have all signatures of approval for all updated NSPs, including, but not limited to, the Phoenix House approving supervisor, the County Worker, the child, and the parents, when applicable. In addition, if County Worker signatures cannot be obtained in a timely manner, Phoenix House shall ensure that efforts to obtain signatures are documented and attached to the updated NSPs in compliance with the County Contract and standards.

3. All children are provided with counseling and other services, as required by the children's identified needs, including, but not limited to, educational assistance and other individual, group, and family counseling services in accordance with Title 22 and County Contract requirements. In addition, all services provided shall be properly and clearly identified in each child's file and all updated NSPs.

Education and Workforce Readiness

A review of the children's files revealed that six (6) of the seven (7) children were in full compliance with this area. However, one of the children did not have proof of school enrollment within three (3) days of placement. The child's records showed that he was enrolled five (5) days after placement without any explanation provided. As a result Phoenix House was out of compliance with element "Children are enrolled in school within three school days".

Recommendation

Phoenix House management shall ensure that:

1. All children are enrolled within three (3) school days, as mandated by County Contract Statement of Work (SOW). If children cannot be enrolled in a timely manner, a clear explanation shall be provided in each child's NSPs and files, with documentation of the Group Home's efforts to comply with all regulations and the California Education Code.

Psychotropic Medication

Seven children's files were reviewed, and of those, four (4) were listed as being on psychotropic medication. However, only one (1) of those four (4) children was in full compliance with this area. Phoenix House was out of compliance with the element "Current Court-Approved Authorizations are on file" based on the following:

- Three of the children in this sample did not have appropriate court-approved authorizations in their files. One of these children had the current court-approved authorizations for medication on file; however, the approved dosages were unclear and could not be established. The second child had a court authorization on file indicating that the child was no longer taking any medication, but the NSPs indicated the child was taking medication. The third child had NSPs which indicated the child had court authorization to take medication, but there were no court-approved authorizations provided. Therefore, there was a conflict of information in all three (3) of the children's files.

Recommendation

Phoenix House management shall ensure that:

1. All of the children placed at the Group Home that are taking psychotropic medication have the most current court-approved authorizations (JV-223s) in their files. In addition, the children's updated NSPs shall coincide with the court authorizations, clearly indicating the prescribed authorized medications and dosages.

Personal Rights and Social/Emotional Well-Being

Interviews were conducted with all seven (7) children to ensure services provided. The child interviews revealed the following deficiencies:

- Four (4) children complained of unfair consequences and discipline. Two of the children reported that the agency does not implement any disciplinary action against children who AWOL and return. They felt that if there were any consequences for running away and returning, then fewer residents would AWOL. The other two (2) children complained that the agency is not consistent in disciplinary action for small infractions (i.e. being out of bounds, verbal threats towards other residents). They argued that the penalties are excessively harsh (i.e. write-ups and court notifications, respectively). As a result Phoenix House was out of compliance with element "Children report the consequences for not following the rules are fair".

- One of the children alleged that on one (1) occasion one (1) of the other residents was AWOL for several hours without staff knowing. The child indicated that the reason staff was unaware of the child's absence was because they had too many activities going on at the same time, making it difficult to maintain accurate body counts. Although this allegation could not be verified, based on the child's interview response it was determined that Phoenix House was out of compliance with element "Children are supervised by staff".

- Three of the children also complained that Phoenix House staff can be disrespectful towards the residents. One of these children reported that, in general, some of the staff can be rude at times. Another complained that there is one (1) specific female staff member that calls the female residents "bitch" on a consistent basis (refused to identify the staff member). The third child indicated that when staff get upset with residents they tend to belittle and use profanity towards them. As a result, based on these statements, Phoenix House was out of compliance with element "Children are treated with respect".

- Two (2) of the seven (7) children complained that they felt they did not have sufficient privacy during telephone calls or the right to receive mail. The first child stated that their counselor "eavesdrops" and listens to their entire telephone conversations with family members. The child indicated that telephone calls are only allowed in the counselor's office in the presence of the counselor, which is an uncomfortable setting to speak freely. The second child complained that she was not allowed to receive mail from her sister who was detained at Juvenile Hall at the time of her placement. The child indicated that she has been informed by family members that her sister sent her several letters that she never responded to. She indicated that Group Home staff never gave her any correspondence from her sister. Both allegations were looked into and the claims could not be substantiated. However, based on the children's statements it was determined that Phoenix House was out of compliance with element "Children are allowed to have private telephone calls and to send and receive unopened mail".

- One (1) of the seven (7) children indicated that she was not offered any mentorship program participation. This child's permanency plan upon completion of the program was to transition into a transitional living program due to lack of family connections. During the interview process, this child indicated that she was not aware of any such mentorship program and was not offered to participate in any such program by the Group Home. A review of the child's file and NSPs confirmed her statement. As a result Phoenix House was out of compliance with the element "Children are offered to participate in mentorship program".

- One (1) of the children stated that they did not feel they were allowed to practice their preferred religious denomination. The child stated that she requested to attend Catholic Church services, but the staff informed her that only Christian services were available to residents. According to the child, the staff's response to her request was, "It's still God". The child's allegation could not be confirmed: however, based on her statement, Phoenix House was determined to be out of compliance with the element "Children are allowed to attend or not attend religious services of their choice".

- One of the children also indicated that the agency does not allow the children to provide feedback on the types of recreational activities they would like to engage in. The child stated that the Group Home staff only allow the residents to engage in sports activities such as basketball or soccer and are not allowed to sit and talk during recreation time. This child stated that he is not a physically activity person and would rather engage in activities like board games or casual conversations. Based on this child's statement, Phoenix House is out of compliance with the element of "Children are given the opportunity to participate in planning recreational activities with the staff".

- Three of the children complained that the Group Home does not provide sufficient extra-curricular activities for the residents. All three (3) of the children stated that the only after school program offered to residents is art therapy. Outside of that, there are no other such activities for residents to choose from. As a result Phoenix House was out of compliance with the element "Children are given the opportunity to participate in extracurricular or community activities".

- Of the four (4) children taking psychotropic medication, one (1) indicated that he did not understand his right to refuse the medication. During the interview the child indicated that he thought that he would receive disciplinary action for refusing to take his medication. He stated that the staff would tell him that he cannot refuse his medication or he will be given a write up. Based on the child's statement, Phoenix House was out of compliance with the element "Children are informed about their right to refuse psychotropic medication".

Recommendation

Phoenix House management shall ensure that:

1. The agency follows the disciplinary guidelines as identified in their program statement and that it is in accordance with Title 22 standards and the County Contract. In addition, children shall be properly notified of the disciplinary policy so that they clearly understand the house rules and discipline procedures.

2. Staff are aware of children's whereabouts at all times and during all activities. If any children are discovered to be missing, AWOL protocols shall be implemented in accordance with the program statement. Administrative staff shall also ensure that proper staffing ratios are maintained to meet the needs of any ongoing activities, to ensure that proper supervision levels are maintained at all times.

3. Children are treated with respect at all times and by all employed staff members. Staff shall also refrain from the use foul language, derogatory comments towards residents, or disrespectful behavior. Staff shall treat children in accordance with their personal rights and Title 22 standards.

4. Children are provided with sufficient and adequate privacy during telephone calls, in accordance with Title 22 and children's personal rights. Children shall also be clearly informed of the telephone privacy policy and be afforded a comfortable environment during calls so that children can speak freely with family members and other contacts. In addition, children shall also be allowed to send and receive mail correspondence with family members and other important people in the children's lives and in accordance with Title 22 and personal rights.

5. Mentorship programs are offered and made readily available for children that do not have any established important relationships with anyone outside of the agency, as required by Title 22 and County Contract standards.

6. Children are allowed to participate in religious church services of their choice, within reason, and in accordance with Title 22 and County Contract requirements. Furthermore, if the agency is not able to meet the child's request, the reason shall be documented in the child's file and/or NSPs.

7. Children are allowed to provide input on the types of recreational activities provided by the agency. The activities offered shall also meet the needs of the children and in accordance with children's requests, if appropriate. The reasonable and prudent parent standard shall also be used in the implementation of children's feedback and requests.

8. Children are provided with a sufficient variety of extracurricular and community activities to meet their social enrichment needs, and are in accordance with Title 22 and County Contract standards. Children shall also be made aware of all said activities and shall be allowed to participate in the activities of their choice. The reasonable and prudent parent standard shall be followed in the children's participation of such activities.

9. Children are made aware of their right to refuse psychotropic medication, in accordance with Title 22 standards and the County Contract. Children shall have a clear understanding of this right and shall also clearly understand that refusal to take medication will not result in any disciplinary action.

Personal Needs/Survival and Economic Well-Being

Of the seven (7) children interviewed, two (2) indicated that they are not provided with youth development services/daily living services (YDS/DLS). The first child, who is 17 years old, stated that upon arrival to the Group Home she inquired about college enrollment and possible enrollment in some type of job corp. program, but that she never received any follow up information from her counselor. The second child, a 16 year old resident, stated that he has not been offered to participate in any type of YDS services program and that the only DLS services provided are simple house chores. A review of their NSPs verified their statements. As a result Phoenix House is out of compliance with element "Children are provided with youth development or daily living skills services".

Recommendation

Phoenix House management shall ensure that:

1. Children are provided with YDS and daily living skills services in accordance with Title 22 standards and the County Contract. In addition, the services provided shall meet the individual needs of each child, based on their age, permanency plan, and capabilities, or other relevant factors. The reasonable and prudent parent standards shall be followed in providing of these services.

Discharged Children

As part of the review, three (3) discharged children's files were reviewed for compliance with permanency efforts. Of the three (3) files, only one (1) was out of compliance with this area. According to this child's NSPs, her discharge plan was to return to her father's home upon completion of the program; however, the discharge summary indicated that the child was transferred to another Group Home within two (2) months of placement. As a result Phoenix House is out of compliance with element "The Group Home discharged the child in accordance with the NSP permanency plan, or to a lower level of care".

Recommendation

Phoenix House management shall ensure that:

1. All efforts to discharge children to a lower level of care are made and that these efforts are properly and clearly documented in the children's files and NSPs. In addition, all barriers to the permanency plan shall also be properly and clearly documented in accordance with Title 22 standards and the County Contract.

Personnel Files

As part of the review, five (5) staff files were reviewed for compliance with Title 22 and County Contract standards. Phoenix House was out of compliance with four (4) of the 14 elements as follows:

- Of the five (5) files, only one (1) did not have the proper educational background or previous experience documented in their file. This staff member did not have any documentation in their file to indicate that they were qualified enough to fill their position with Phoenix House. As a result Phoenix House is out of compliance with element "Staff met educational and/or experience requirements in accordance with the agency's program statement and Title 22".

- Of the five (5) files reviewed, four (4) did not have proof of current driver's license placed in their files. The first two (2) staff files were missing copies of their licenses, and the other two (2) had expired copies on file. As a result Phoenix House is out of compliance with element "Staff had current California driver's license on file".

- One out of the five (5) files was also missing proof of initial 24 hours of training upon hire. The staff's file did not have any documentation to prove that they received the required training prior to supervising placed children. As a result Phoenix House is out of compliance with element "Staff received initial 24 hour training".

- One out of the five (5) files was missing proof of the required 20 hours of annual training. The staff's file only had 14.5 hours logged for the previous year's training. As a result Phoenix House is out of compliance with element "Staff received 20 hour of on-going training".

Recommendation

Phoenix House management shall ensure that:

1. Each staff has their qualifications to work with the agency documented in their files at all times and are made available for review upon request. This shall include any diplomas, previous work experience, or other documents that verify their qualifications, in accordance with Title 22 and County Contract requirements.

2. Every staff member that is required to transport children has current and valid copies of their driver's licenses placed in their files at all times and are made available for review upon request. This shall be done so as to be in compliance

with Title 22 and County Contract regulations in order to ensure that transporting employees are in compliance California driving laws.

3. All staff members receive the required initial training hours upon hire, and prior to the supervision of children. In addition, the training courses and hours shall be clearly documented in each staff's files and are made readily available upon request in order to be in compliance with Title 22 standards and the County Contract.

4. All staff members receive the required annual training hours as mandated by Title 22 standards. In addition, Phoenix House shall have clear and proper documentation of training hours received for each staff member on file, and shall be made available for review upon request.

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

PPQA/GHM's last compliance report dated July 8, 2016, identified 20 recommendations.

Results

Based on the follow-up, Phoenix House fully implemented five (5) of the 20 previous recommendations for which they were to ensure that:

- Children's initial medical examinations were conducted within 30 days of placement.
- Children's initial dental examinations were conducted within 30 days of placement.
- Children are provided with life books and are encouraged to use them.
- Discharged children made sufficient progress towards their permanency plan and graduate from the program.
- All staff files maintained proof of medical clearances upon employment in their files.

However, the follow-up discovered that Phoenix House failed to fully implement 15 of the previous 20 recommendations for which they were to ensure that:

- All facility vehicles used to transport children are maintained in compliance with Title 22 standards. During last year's review the agency was cited for failure to maintain vehicle emergency equipment in order due to having discharged fire extinguishers in three (3) of the six (6) vehicles. As aforementioned under the area of "Licensure/Contract Requirements" of this year's review, Phoenix House had two (2) vehicles with either missing or misplaced proof of registration on file. In addition, five (5) of the vehicles did not have proper maintenance logs on file. Therefore, this is the second year that the agency is out of compliance with this element, although for different reasons.

- The common areas of the Group Home are well maintained. In last two (2) year's reviews the agency was cited for not having the children's personal rights posted in a visible area. As aforementioned under the area of "Common quarters are well maintained" of this year's review, the agency was cited for having an improperly pressurized fire extinguisher in the hallway to the Odyssey Unit. As a result, this is the third year the agency is out of compliance with this element, although for slightly different reasons.

- The children's bedrooms are well maintained. During the last two (2) year's reviews, Phoenix House was cited for relatively similar deficiencies such as excessive graffiti, improperly working bedroom restrooms, and general wear and tear to the furniture, doors, and walls. As aforementioned under the area of "Facility and Environment" of this year's review, Phoenix House was cited again for similar deficiencies in the bedrooms, although there were far fewer bedrooms cited for deficiencies.

- The children's initial and updated NSPs had the authorizing signatures by their county workers. In last year's review, two (2) of the children did not have the signatures of approval for their initial NSPs and one (1) of the other children had an updated NSP that only showed one (1) attempt to obtain signature, without success. As aforementioned under the area of "Maintenance of Required Documentation and Service Delivery" of this year's review, Phoenix House was found to have the same deficiency. Although all of the children in this year's review had the authorizing signatures for the updated NSPs, two (2) of them had initial NSPs that did not have the CSW/DPO approval signature and did not provide the efforts made by the Group Home. In addition, a third child had the DPO/CSW signature completed late. As a result, this is the second year in a row that the agency is out of compliance with this element.

- The children's updated NSPs indicated sufficient progress made in their programs. In last year's review, three (3) of the children in the sample size did not meet this requirement. One of the children had "Achieved Goals"

that did not match with the rest of the NSP. Two other children also had goals that were not measureable. Therefore, the progress of these children could not be fully assessed. As aforementioned in the area of "Maintenance of Required Documentation and Service Delivery" of this year's review, Phoenix House had the same issues cited again for the second year in a row. Three of the children's updated NSPs in this year's sample size did not properly document the goals section of the updated NSPs because the goals were unclear, convoluted, and/or unmeasurable, making it unclear if they were achieved.

- The children were receiving therapeutic services. In last year's review, Phoenix House did not properly document the family participation in family therapeutic sessions in the file of one (1) of the children. The child's NSPs only indicated that he was to participate in family sessions without indicating what family member(s) would be participating in the sessions or their level of involvement. As aforementioned in the area of "Maintenance of Required Documentation and Service Delivery" of this year's review, Phoenix House had similar issues again this year. One of the children in this year's sample size did not have therapeutic services properly documented because individual/group/family therapy and/or counseling were not documented in the child's NSPs. Therefore, this is the second year that the agency is out of compliance with this element.

- The Group Home documented efforts to assist the children in maintaining important relationships. In last year's review, Phoenix House did not comply with this requirement for one (1) of the children. The child's NSPs did not provide any information on the status of the child's relationship with the biological mother or the efforts made by the Group Home to maintain this relationship, even though the child was living with an aunt. As aforementioned in the area of "Maintenance of Required Documentation and Service Delivery" of this year's review, Phoenix House had a similar deficiency cited for one (1) of the children in this year's review. For this child, the visitation section did not indicate the progress of child's relationship with the parents and/or the grandparents or their level of involvement in the child's program. Therefore, this is the second year that the agency is out of compliance with this element.

- Children's initial NSPs were timely and comprehensive. In last year's review, Phoenix House was out of compliance with this element because six (6) out of the seven (7) initial NSPs were not comprehensive. There were problems with the concurrent case plans, NSPs had conflicting information throughout the reports, or had missing and/or inaccurate information. The initial NSPs were also deficient because the goals were not properly developed in accordance with SMART guidelines and because,

in general, many of the sections appeared to be generic and were not case-specific. As aforementioned in the area of "Maintenance of Required Documentation and Service Delivery" of this year's review, two (2) of the children did not have clear concurrent case plans identified in the initial NSP, and three (3) of the children did not have SMART goals established for the third year in a row.

- Children's updated NSPs were timely and comprehensive. In last year's review, Phoenix House was out of compliance with this element because four (4) of the children did not have comprehensive updated NSPs. The updated NSPs had problems with the concurrent case plans and there were inconsistencies throughout the report. The goals section also did not use the SMART guidelines and had sections that were generic and not case-specific. As aforementioned in the area of "Maintenance of Required Documentation and Service Delivery" of this year's review, the same issues were discovered again for the third year in a row, in that case plans were unclear and the NSPs had contradictory information, as well as goals that were not clearly developed and maintained.

- Documentation of academic progress was properly maintained. In last year's review, Phoenix House was out of compliance with this requirement because one (1) of the children in the sample size did not have clear documentation of the child's scholastic progress. As aforementioned in the area of "The Group Home provided children with counseling and other services" of this year's review, the Group Home was deficient again this year because the NSPs for one (1) of the children indicated that the child was behind on school credits, but there was no documentation indicating if any tutoring or other services were being provided to assist the youth towards making educational progress.

- Documentation of the Youth Development Services (YDS) provided were properly maintained. In last year's review Phoenix House was out of compliance with this requirement because two (2) of the children in the sample size were missing information. Their NSPs were either unclear on the child's ILP enrollment status or they did not document the types of YDS services being provided. In addition, one (1) of these children reported that they were not receiving any type of Independent Living Program (ILP) services. As aforementioned in the area of "The Group Home provided children with counseling and other services" of this year's review, the Group Home was deficient again this year because the NSPs for one (1) of the children indicated that the child required ILP services; however, there was no documented proof that these services were provided by the Group Home.

- The Group Home uses a fair rewards and discipline system. In last year's review, Phoenix House failed to comply with this requirement because three (3) of the seven (7) children interviewed indicated that certain disciplinary actions taken are a violation of their personal rights. The children in last year's sample size stated that as part of the discipline system at Phoenix House, children can be punished by having home passes and family visits cancelled. As aforementioned under the area of "Personal Rights and Social/Emotional Well-Being" of this year's review, Phoenix House was again found to be out of compliance with this element. Although in this year's review there were no complaints of personal rights violations as related to disciplinary action, there were still complaints of an unfair implementation of the rules. Children complained that certain small infractions resulted in serious action taken such as notification to court for verbal threats made in anger. They also complained that certain infractions such as running away and returning are not punished by Group Home staff. As a result, Phoenix House is out of compliance with this element for the second year in a row.

- Children are given opportunities to participate in extra-curricular, enrichment and social activities. In last year's review, Phoenix House was out of compliance with this requirement because one (1) of the children in the sample size complained that activities are frequently cancelled due to staff shortages. As aforementioned under the area of "Personal Rights and Social/Emotional Well-Being" of this year's review, three (3) of the children interviewed complained that the Group Home only offers "Art Therapy" as an after-school extra-curricular activity. As a result Phoenix House is out of compliance with this element for the second year in a row.

- Children are discharged according to their permanency plan. In last year's review, Phoenix House was out of compliance with this requirement because one (1) of the children was removed from the facility on a "7-day" removal request due to insufficient progress made in their drug rehabilitation and sobriety. As aforementioned under the area of "Discharged Children" of this year's review, one (1) of the children had an unclear permanency plan documented. According to the child's NSPs, they were to return home to the father upon graduating from the program. However, the discharge letter for this child indicated that the child was re-placed at a different Group Home after completing the Phoenix House program within two (2) months of placement. The documentation provided was unclear on which was the child's actual permanency plan. Therefore, Phoenix House is out of compliance with this element for the second consecutive year.

- The staff files have all of the required training on file. In last year's review, Phoenix House failed to meet this requirement because three (3) of the five

(5) staff files reviewed were missing documentation of training received. Two of the staff did not have proof of emergency intervention training, while the third staff was missing proof of CPR training as well as logged hours of the required annual training. As aforementioned under the area of "Personnel Files" of this year's review, two (2) staff files were also out of compliance with this requirement. The first staff member did not have the required initial training received upon hire in their file. The second staff file only had 14.5 of the required 20 annual training hours logged for the previous year. As a result, Phoenix House was out of compliance with this element for the second year in a row.

MOST RECENT FISCAL REVIEW CONDUCTED BY THE AUDITOR-CONTROLLER

A current fiscal review of Phoenix House by the Auditor Controller was conducted during the fiscal periods of 2012-13, and 2013-14. A report dated June 12, 2015, was posted by the Auditor Controller.

11600 Eldridge Avenue
Lake View Terrace, CA 91342

T818 686 3073
F818 899 6501
www.phoenixhouse.org

Phoenix House
Rising Above Addiction

April 5, 2017

Deputy Probation Officer Armando Juarez, DPO II
Los Angeles County Probation Department
Group Home Monitoring Unit
11701 S. Alameda St., 2nd Floor
Lynwood, CA 90262

RE: Phoenix House Academy of Los Angeles- Group Home Corrective Action

Dear DPO Juarez,

Please find attached the corrective action plan in response to the Group Home Monitoring Review Field Exit Summary on March 2, 2017. The corrective action plan was developed in collaboration with the Phoenix House Managers and Directors to ensure timely correction and sustained compliance in all of the areas.

We appreciate the opportunity to improve our program operations and services to ensure we provide the best quality of care to the youth placed in our care.

Should you have any questions regarding the corrective action plan, please feel free to contact Errol Small, Director of Residential Services at (818)686-4766 or Chinling Chen, Sr. Program Director at (818)686-3020.

Sincerely,

Errol Small, MFTI
Director of Residential Services

Chinling Chen, LCSW
Sr. Program Director

PHOENIX HOUSE GROUP HOME
CORRECTIVE ACTION PLAN
March 2, 2017

I. Licensure/Contract Requirements

1. Findings:

Vehicle proof of registration was missing and misplaced for two vehicles.

- *Vehicle #2-Proof of registration missing from vehicle packet.*
- *Vehicle #3-Proof of registration was misplaced (was found in packet for vehicle #2).*

Root Case Analysis and Quality Improvement Plan:

Facility vehicles are either owned by Phoenix House or leased. A vehicle check list is completed before vehicles are used each day. The reviewed checklist is signed by the staff member performing the check and is kept on file. Routine maintenance for all vehicles is coordinated by the Supervisor. Phoenix House maintains a database of all vehicles, drivers permitted to operate these vehicles, mileage, repairs, maintenance log, and other items necessary for the smooth operation of the transportation program. Vehicles deemed deficient during the course of the Group Home Monitoring Review derived from the failure of Phoenix House staff in following the procedures related to the handling of vehicle registrations and the completion of maintenance logs

Corrective Action Plan:

Facility Manager/Supervisor Steven Levitt reviewed the driver responsibilities with the staff on March 24, 2017. Monitoring for compliance with the procedures will be the responsibility of the Facility Manager/Supervisor from this point forward.

Enclosed is a copy of the General Vehicle Operating Procedures, Monthly Vehicle Inspection Form and the Vehicle Trip Log.

2. Findings:

Maintenance Logs were missing for five vehicles.

- *Proof of most current service was missing (veh* #1-07/15/16, *veh* #-04/21/16, *veh* #3-07/14/16, *veh #7-04/19/16, veh #8-05/27/16).*

Root Case Analysis and Quality Improvement Plan:

Facility vehicles are either owned by Phoenix House or leased. A vehicle check list is completed before vehicles are used each day. The reviewed checklist is signed by the staff member performing the check and is kept on file. Routine maintenance for all vehicles is coordinated by the Supervisor. Phoenix House maintains a database of all vehicles, drivers permitted to operate these vehicles, mileage, repairs, maintenance log,

and other items necessary for the smooth operation of the transportation program. Vehicles deemed deficient during the course of the Group Home Monitoring Review derived from the failure of Phoenix House staff in following the procedures related to the completion of maintenance logs

Corrective Action Plan:
Facility Manager/Supervisor Steven Levitt reviewed the driver responsibilities with the staff on March 24, 2017. Monitoring for compliance with the procedures will be the responsibility of the Facility Manager/Supervisor from this point forward.

Enclosed is a copy of the General Vehicle Operating Procedures, Monthly Vehicle Inspection Form and the Vehicle Trip Log.

3. Findings:
Missing weekly allowance logs for clients.

- *Child #1-Missing log for 09/26* & 11/28.
- *Child #3-September logs not in order (end of month balance was unclear allowance changed from $50 at end of September to $27 for beginning of October without documentation of deductions), and missing log for 10/24.*
- *Child #4-Missing logs for entire month of November and December.*
- *Child #5 -Missing log for entire month of November, and missing log for* 12/19 & 12/26.
- *Child #6-Missing logs for* 12/1/& 12/26.

Overall, the children's logs were difficult to read (many of the logs did not document the payments for the last week of each month).

Root Case Analysis and Quality Improvement Plan:
The noted deficiency regarding the maintenance of weekly allowance logs derived from the failure of Phoenix House staff to properly complete, submit, and file the required logs.

Corrective Action Plan:
To ensure weekly allowance logs are accurately maintained, Phoenix House is implementing the following corrective action plan, effective March 1, 2017.

1. Financial balances of weekly allowance and job function will be printed and forwarded to Unit Manager and/or designee for clients and staff to review and sign on a weekly basis.

2. Signed Weekly Account Balance sheets will be returned to Project Administrators mail box for filing in individual unit binders.
3. Units will keep back-up copies of signed financial forms in a binder on each individual unit.
4. The Project Administrator will audit all financial logs on a monthly basis to ensure all logs were collected and signed. The Project Administrator will inform the Unit Manager of any missing logs and Unit Manager will be responsible for following up with unit staff to ensure PA receives the financial logs in a timely manner.

4. Findings:

Missing monthly clothing logs for clients.

- *Child #1-Missing logs for July, August, &December. Child #2-Missing log for December.*
- *Child #3-Missing log for June, July, August, September, and December.*
- *Child #4-No clothing logs found.*
- *Child #5-Missing logs for September & December.*
- *Child #6-Missing logs for December.*
- *Child #7-Missing logs for December.*

Root Case Analysis and Quality Improvement Plan:

The noted deficiency regarding the maintenance of monthly clothing logs derived from the failure of Phoenix House staff to properly complete, submit, and file the required logs.

Corrective Action Plan:

To ensure monthly clothing logs are accurately maintained, Phoenix House is implementing the following corrective action plan, effective March 1, 2017.

1. Clothing Allowance forms have been modified with a simplified form that will indicate the $50 monthly allowance amount spent with description (see attached example) on the 1st day of each month. Clients will be informed of all balances every month. Senior unit staff or designee will be responsible for collecting signatures and will ensure the Project Administrator receives the forms within 1 week. The Project Administrator will file the clothing logs in a binder located in the Program Directors office.
2. Units will keep back-up copies of signed financial forms in a binder on each individual unit.
3. The Project Administrator will audit all financial and clothing logs on a monthly basis to ensure all logs were collected and signed. The Project Administrator will inform the Unit Director of any missing logs and Unit Director will be responsible for following up with unit staff to ensure PA receives the financial logs in a timely manner.

Additionally, a modified Clothing Allowance Form will be implemented to facilitate the process. Please find enclosed a copy of the revised Clothing Allowance form.

5. Findings:
SIRs were not documented in the quarterly NSPs for three clients.

- *Child #1-Quarterly NSP indicates Sexual Behavior on 08/28 -No I-Track in system.*
- *Child #3-ITrack#472325 indicated child went AWOL on 08/03 (not documented in quarterly report). I-Track #477037 indicated the child was involved in a fight on 09/09 (not documented in quarterly report).*
- *Child #7-I-Track #479496 indicates that the child was involved in a fight on 10/01 (Not documented in quarterly report). I-Tracks # 481891, #481943, & #486652 all indicate that the child went AWOL on 10/21, 10/22 and 11/19, respectively (not documented in quarterly report).*

Root Case Analysis and Quality Improvement Plan:
Due to recent staff turnover in the Case Manager Department, identified individuals in the role of Case Manager have not benefited from a comprehensive training that would further assist in their development within the assigned role.

Corrective Action Plan:
To ensure NSPs are completed accurately and documents all applicable client SIRs, a NSP training was offered on March 8, 2017 with the Unit Managers and Case Managers to review the audit findings. The training provided staff with examples of proper documentation of client SIRs. As part of our agency clinical transformation, Unit Managers will continue to be trained in a manner that allows for them to better support Case Manager immediate needs towards specific aspects related to NSP documentation, emphasizing areas that have been indicated within recent audits. Monitoring for compliance will be the responsibility of the Unit Managers and QA.

Please find enclosed a copy of the NSP Training Agenda, sign in sheet, and training materials.

II. Facility and Environment

1. Findings:
Common quarters were not well maintained.

- *Odyssey Unit-Fire extinguisher was not in proper pressure range.*

Root Case Analysis and Quality Improvement Plan:
The deficiency with the fire extinguisher was due to the fire extinguisher being discharged between the scheduled monthly inspections and the Maintenance Team not being appropriately notified in a timely manner to service/replace the unit.

Corrective Action Plan:
The Maintenance Team inspects all fire extinguishers on a monthly basis throughout the building to ensure proper pressure range.

The policy for maintaining fire extinguishers is as follows:

- All fire extinguishers are tested and serviced annually by a licensed contractor.
- All fire extinguishers are inspected monthly by the maintenance department and the tags on the fire extinguishers are signed.
- Any fire extinguishers not within pressure range will be serviced/replaced immediately.

To ensure fire extinguishers are serviced immediately after discharge, the staff who utilized the fire extinguisher must follow the maintenance policy outlined below to notify the Maintenance Team immediately:

1. Complete a maintenance request form.
2. Email completed form to the Director of Operations
3. All forms will be reviewed by the Director of Operations daily and work order will be created.
4. All repairs will be handled on the order of priority.
5. If repairs cannot be completed in-house, an outside vendor will be used

Monitoring for compliance to the above policies will be the responsibility of the Director of Operations and Director of Residential Services.

2. Findings:
Children's bedrooms were not well maintained.

- *Amethyst Unit--Rm. #43-Restroom light not working, Rm. #52-Restroom floor board loose, Rm. #58-Cork board is loose, Rm. #60-Dresser drawers broken & not functioning properly.*
- *Odyssey Unit--Rm. #224-Restroom toilet not flushing properly & large graffiti behind entrance door, Rm. #225- Restroom shower handle is broken, Rm. #228-Restroom shower handle is broken, Rm. #240-Entrance door requires door stop (door handle causing hole in wall behind door), Rm. #245-Entrance door requires door stop as well.*
- *Renaissance Unit--Rm. #501-Entrance door requires door stop, Rm. #506-Restroom light cover is missing.*

Root Case Analysis and Quality Improvement Plan:
Facility maintenance deficiencies identified during the course of the Group Home Monitoring Review derived from the need for consistent implementation and follow through of maintenance policy outlined below.

Corrective Action Plan:
Farid Rasekhi, Director of Facilities Management and Property reviewed and corrected the deficiencies noted during the audit on March 24, 2017. To ensure maintenance issues are resolved in a timely manner moving forward, the following policy for reporting maintenance problems/issues was implemented:

1. Complete a maintenance request form
2. Email completed form to the Director of Operations
3. All forms will be reviewed by the Director of Operations daily and work order will be created.
4. All repairs will be handled on the order of priority.
5. If repairs cannot be completed in-house, an outside vendor will be used.

Additionally, staff will complete the Room Run Sheet on a daily basis as part of the effort to identify any maintenance issue. Monitoring for compliance will be the responsibility of the Director of Operations, Director of Residential Services, and the Unit Managers.

Please find enclosed a copy of the Maintenance Request Form and Room Run Sheet.

III. Maintenance of Required Documentation and Service Delivery

1. Findings:
Initial NSPs were not completed accurately and on time for seven NSPs.

- *Child #4 & 5-Concurrent case plans were unclear and contradictory.*
- *Child #2, 4, & 7-Did not have SMART goals. Goals were unclear, unmeasureable, or missing.*
- *Six out of the seven children were missing required signatures from either the Group Home supervisor, DPO/CSW, child, and/or parents. Signatures were either late or missing and efforts to obtain DPO/CSW were not documented.*

Root Case Analysis and Quality Improvement Plan:
Due to recent staff turnover in the Case Manager Department, identified individuals in the role of Case Manager have not benefited from a comprehensive training that would further assist in their development within the assigned role.

Corrective Action Plan:
To ensure NSPs are completed accurately and on time, a NSP training was offered on March 8, 2017 with the Unit Managers and Case Managers to review the audit findings. The training provided staff with a review of timeframes for NSP completion, instructions for obtaining Client/Supervisor/CSW/DPO signature and approval, and appropriate documentation of attempts, if applicable. As part of our agency clinical transformation, Unit Managers will continue to be trained in a manner that allows for them to better support Case Manager immediate needs towards specific aspects related to NSP documentation, emphasizing areas that have been indicated within recent audits NSP's to ensure comprehensive and quality delivery of services. Monitoring for compliance will be the responsibility of the Unit Managers and QA.

Please find enclosed a copy of the NSP Training Agenda, sign in sheet, and training materials.

2. Findings:

Updated NSPs were not completed accurately and on time for seven NSPs.

- *Child #3-Case plan changed from reunification with aunt to PPLA without explanation.*
- *Childe #1 & 5-Concurrent case plans were either unclear or were not properly updated.*
- *Child #5-Visitation section did not clarify progress of child's relationship with parents/grandparents or indicate their level of involvement.*
- *Child #1, 5, & 7- Did not have SMART goals. Goals were unclear, unmeasureable, or missing.*
- *All four of the children with updated NSPs were missing required signatures from either the Group Home supervisor, DPO/CSW, child, and/or parents. Signatures were either late or missing and efforts to obtain DPO/CSW were not documented.*

Root Case Analysis and Quality Improvement Plan:
Due to recent staff turnover in the Case Manager Department, identified individuals in the role of Case Manager have not benefited from a comprehensive training that would further assist in their development within the assigned role.

Corrective Action Plan:
To ensure NSPs are completed accurately and on time, a NSP training was offered on March 8, 2017 with the Unit Managers and Case Managers to review the audit findings. The training provided staff with a review of timeframes for NSP completion, instructions

for obtaining Client/Supervisor/CSW/DPO signature and approval, and appropriate documentation of attempts, if applicable. As part of our agency clinical transformation, Unit Managers will continue to be trained in a manner that allows for them to better support Case Manager immediate needs towards specific aspects related to NSP documentation, emphasizing areas that have been indicated within recent audits NSP's to ensure comprehensive and quality delivery of services. Monitoring for compliance will be the responsibility of the Unit Managers and QA.

Please find enclosed a copy of the NSP Training Agenda, sign in sheet, and training materials.

3. Findings:
Group Home did not update NSP sections to indicate counseling and other services provided.

- *Child #1- Education section indicates child is behind on credits, but updated section did not indicate tutoring or other services provided (left blank). Life Skills section of initial NSP indicated youth to receive ILP services but updated section was left blank.*
- *Child #3- Dates of individual/group/family therapy and/or counseling not documented in Mental Health section.*

Root Case Analysis and Quality Improvement Plan:
Due to recent staff turnover in the Case Manager Department, identified individuals in the role of Case Manager have not benefited from a comprehensive training that would further assist in their development within the assigned role.

Corrective Action Plan:
To ensure NSPs are completed accurately and on time, a NSP training was offered on March 8, 2017 with the Unit Managers and Case Managers to review the audit findings. The training provided staff with a review of timeframes for NSP completion, instructions for obtaining Client/Supervisor/CSW/DPO signature and approval, and appropriate documentation of attempts, if applicable. As part of our agency clinical transformation, Unit Managers will continue to be trained in a manner that allows for them to better support Case Manager immediate needs towards specific aspects related to NSP documentation, emphasizing areas that have been indicated within recent audits NSP's to ensure comprehensive and quality delivery of services. Monitoring for compliance will be the responsibility of the Unit Managers and QA.

Please find enclosed a copy of the NSP Training Agenda, sign in sheet, and training materials.

IV. Education and Workforce Readiness

1. Findings:

One child's NSPs did not accurately indicate school enrollment or provide an explanation of late school enrollment.

- *Child #4 -Child's file indicated he was placed 5 days after placement, but NSP did not provide explanation for late enrollment.*

Root Case Analysis and Quality Improvement Plan:

Due to recent staff turnover in the Case Manager Department, identified individuals in the role of Case Manager have not benefited from a comprehensive training that would further assist in their development within the assigned role.

Corrective Action Plan:

To ensure NSPs are completed accurately and on time, an NSP training was offered on March 8, 2017 with the Unit Managers and Case Managers to review the audit findings. The training provided staff with examples of proper documentation of client services. As part of our agency clinical transformation, Unit Managers will continue to be trained in a manner that allows for them to better support Case Manager immediate needs towards specific aspects related to NSP documentation, emphasizing areas that have been indicated within recent audits. Monitoring for compliance will be the responsibility of the Unit Managers and QA.

Please find enclosed a copy of the NSP Training Agenda, sign in sheet, and training materials.

VI. Psychotropic Medication

1. Findings:

Initial and updated NSPs did not accurately indicate date of PMA and accurate dosage of prescribed psychotropic medication.

- *Child #1-JV-220 indicates Benadryl 50-150 mg prescribed, but not indicated in NSP.*
- *Child #5-JV-220 dated 10/4 indicated child was not currently taking any meds but the initial NSP (dated 10/13) indicated child was taking psych meds. In addition, updated NSP (dated 12/13) indicated the date of PMA was 10/25, but the PMA corresponding to this NSP was dated 12/9.*
- *Child #7-Initial NSP (dated 09/23) indicated child has PMA (copy not provided). Updated NSP (dated 11/23) indicated PMA also. Current JV-220 not provided for this NSP. In addition, the JV-223 court approval did not have all pages provided (including prescribed approved meds page).*

Root Case Analysis and Quality Improvement Plan:
Unit Managers have not been provided the level of training that allows for them to accurately review NSP's to ensure comprehensive completion. Furthermore, the influx of new Case Managers within the agency have also caused some challenges, as a formal training has not been produced to provide certain individuals with the level of knowledge needed to demonstrate proficiency in the area of providing comprehensive and timely NSP's.

Corrective Action Plan:
Case Managers and their immediate supervisors will be required to enroll in the next scheduled NSP training to ensure that all aspects related to obtaining information related to PMA's are accurately reflected within NSP's. DPO Juarez will be called to inquire about his availability towards conducting staff training for our current Case Managers that have recently been employed by our agency. DPO Juarez will be contacted by the Residential Director the week of April 10th to inquire about ability for DPO Juarez or a designee to facilitate NSP training for all Case Managers, Unit Managers and Quality Assurance representatives.

Phoenix House Quality Assurance Department has the following process in place to ensure NSPs are completed accurately and in a timely manner.

The process is outlined below:

1. Case Managers completes their NSP within 30 days of start date, the following NSP is due at the 90 day mark, and subsequent NSP's are due every 90 days thereafter.
2. If the Case Managers fails to upload the NSP, Welligent (Electronic Health Record System) notifies QA and a deficiency report is sent out to the Case Manager and their Supervisor.
3. Completed NSP's require the Supervisor's signature. Supervisors review the NSPs for accuracy and signs off on approved NSPs.
4. NSP's are randomly audited for fidelity once per quarter as a part of Phoenix House QRSUR process.

VII. Personal Rights and Social/Emotional Well-Being

1. Findings:
Unfair consequences and discipline as follows:
- *Clients indicated leniency in consequences related to AWOLs.*
- *Clients indicated inconsistency in implementation of disciplinary action.*

Root Case Analysis and Quality Improvement Plan:
The Residential Program experienced turnover in administrators, supervisors, and unit staff, which contributed to inconsistent implementation of a program structure and led to unclear and inconsistent application of consequences and discipline for client's behaviors.

Corrective Action Plan:
Each unit will have general (non- unit specific) rules and expectations displayed in common areas that can be easily read and understood by both clients and members of the treatment team both inside and outside of the units. Also, on display will be the consequences for failing to follow the outlined rules and expectations. These rules will be conceived through a committee comprised of both clients and treatment team members. Review of the rules will also be verbally reinforced during weekly team meetings amongst the units, as well as, during daily meetings with the clients.

All clients will be provided with a copy list of the rules and expectations. Upon admittance into the program, the Admissions team will provide and review the rules and expectations to the client as well as the client's family.

As part of the Initial Required Training, newly hired direct care staff will be trained on the *Positive Approaches to Behavioral Management* and the *Guidelines for Pre/Current/Post AWOL Incident* to ensure the treatment team utilizes a consistent framework for addressing client's behavioral issues. Unit Managers will also review these policies and procedures with staff individually and during team meetings as needed. Additionally, staff will also be required to complete *Positive Behavior Support for Children* training via Relias training system on an annual basis to ensure staff maintains knowledge of positive disciplinary techniques.

Unit Managers will be responsible for monitoring compliance with this corrective action plan.

Please find enclosed a copy of *Positive Approaches to Behavioral Management* and the *Guidelines for Pre/Current/Post AWOL Incident* policy and procedures.

2. Findings:

Improper supervision provided to the clients.

- *One children reported that another client was AWOL for several hours without staff knowing because there were too many activities going on at the same time, causing the staff to be distracted and unable to maintain accurate body counts.*

Root Case Analysis and Quality Improvement Plan:
The noted deficiency is due to treatment team member (s) not actively conducting timely routine checks in regards to the exact whereabouts of each client.

Corrective Action Plan:
At the beginning of each shift, the designated shift supervisor retrieves all necessary documentation from a centralized location needed for the duration of the shift. Included in such, is the "Population Head Count Check Sheet". This document is shift specific and it is reflective of the whereabouts of each client in 30 minute intervals. In addition, the Facility Manager is required to provide a walkthrough of each unit twice during each shift and provide a signature on the Population Head Count Check Sheet each time. Monitoring for compliance will be the responsibility of the Facility Managers and Unit Managers.

As part of the Initial Required Training, newly hired direct care staff will be trained on the topic of Child Care Supervision, which includes instruction on the role and responsibilities of staff, proper supervision techniques, communication and team work; rewards and discipline policies. A booster training will be provided to staff during Unit Meeting by Unit Managers or addressed individually with staff in supervision with Unit Manager, if there are concerns regarding staff supervision issues.

During the twice daily Hub Meetings, each shift supervisor is responsible for discussing staff supervision coverage and the activity schedule to ensure there is adequate staff coverage for the activities planned for the day. If there are coverage issues identified, Facility Managers and Unit Managers will be responsible for ensuring adequate staff coverage is in place.

Please find enclosed a copy of Population Head Count Check Sheet, Initial Required Training checklist, and the Hub Meeting Checklist.

3. Findings:
Clients reported that they were not being treated with respect.

- *Three clients indicated the use of profanity by staff toward residents and that they have been belittled by staff.*

Root Case Analysis and Quality Improvement Plan:
Treatment team members have not been assigned the task of thoroughly explaining Personal Rights to clients and creating greater opportunities to allow for clients to clearly understand what their individual rights entail. Although posted within the milieu environment, Treatment Team members have not exercised the practice of educating clients towards their individual rights either within individual or group sessions.

Corrective Action Plan:
Title XXII Personal Rights are explained to all clients upon admissions by an Admissions Counselor and moving forward will be signed by the client during that point of contact and uploaded into the client's individual chart within our electronic health records. Although Client Personal Rights are posted in common areas within the milieu environment, staff will be required to present monthly seminars to explain Personal Rights to clients in a group session to solicit feedback related to their individual or group concerns. The Emotional Well-Being of each client in the program is paramount and staff members that violate agency codes of conduct or have been identified within a formal grievance by a client will constitute a formal meeting with the immediate supervisor. Documentation generated due to the issuance of a formal grievance by a client will be facilitated by the Unit Manager and forwarded to the Quality Improvement Department. A formal Individual Supervision will also be facilitated by the immediate supervisor of the staff member that has been identified within the grievance and progressive discipline actions will be taken up to and including termination if justified.

Please find enclosed a copy of Phoenix House Client/Consumer Grievances Policy.

4. Findings:
Clients indicated not being allowed have private telephone calls and to send and receive unopened mail.

- *One child reported that his counselor eaves drops on his telephone calls.*
- *One child reported that the staff do not let her receive mail from her sister who was in Juvenile Hall during her placement program.*

Root Case Analysis and Quality Improvement Plan:
The reason for this noted deficiency is due to staff not assisting the client in understanding the protocols provided by Probation and/or DCFS in regards to appropriate outside contact, including but not limited to, communication via mail or telephone calls. Additionally, staff may not be appropriately trained and retrained in the area of Client Rights and Privileges.

Corrective Action Plan:
Unit Managers will review Client Rights and Privileges with staff at the time of hire and will provide continuous training on this issue during Unit Team Meeting on a quarterly basis. Staff will be trained on the following client rights: Clients shall be allowed to place private phone calls to a court assigned probation officer or social worker at any time. All other phone calls are permitted as outlined in the treatment plan. Staff will also be trained that clients are able to receive and/or send mail unless it is prohibited by probation officer, social worker, and/or client's parent(s)/guardian.

All contacts shall be approved by the client's parent(s)/guardian, unless the client is 18 years or older. Additionally, a client's court assigned probation officer/CSW shall review and approve any and all contacts, and may supersede parent(s)/guardian approval. The Reasonable and Prudent Parent Standard may be referenced and applied by the treatment team to assist in determining appropriateness of contact, while taking into consideration the client's age, maturity, and any current treatment/behavioral issues. If phone/mail contact needs to be restricted due to concerns regarding client's best interest, treatment team must consult and receive approval from client's Probation Officer/CSW and appropriately document the restriction in the client's record.

Unit Managers and Case Managers will be responsible for monitoring compliance in this area.

5. Findings:
Clients indicated not being offered a mentorship program.

- *One of the children indicated that they were not aware of a mentorship program despite eligibility.*

Root Case Analysis and Quality Improvement Plan:
The reason for this noted deficiency is due to the Case Managers not being appropriately trained on services and resources available to transitional age youth, who are exiting County systems without family connections.

Corrective Action Plan:
Unit Managers will ensure Case Managers are aware of and fulfill their responsibility to engage youths in discussion regarding mentorship programs. If youths expressed desire to have a mentor, Case Managers are responsible for helping the youth access resources available in the community and through the County to secure a mentor. Additionally, Case Managers are responsible for connecting with the youth's County Social Worker/Probation Officer in exploring extended families and/or significant adults in the youth's life that can serve as a permanent connection for the youth. Unit Managers will be responsible for monitoring compliance in this area.

6. Findings:
Children are not allowed to attend religious services of their choice.

- *One of the children stated that they did not feel they were allowed to practice their preferred religious denomination because when they requested to attend catholic church services, they were told by staff that only Christian services were available.*

Root Case Analysis and Quality Improvement Plan:
The reason for this noted deficiency is due to the staff not being fully trained in the client's rights related to attending religious services of their choice and as a result misinformed client of their rights in this area.

Corrective Action Plan:
Unit Managers will review Title 22 Personal Rights with staff at the time of hire and will review Title 22 Personal Rights with staff on a Quarterly basis during team meetings. Title XXII Personal Rights are explained to all clients upon admissions by an Admissions Counselor. Although Client Personal Rights are posted in common areas within the milieu environment, staff will be required to present monthly seminars to explain Personal Rights to clients in a group session to solicit feedback related to their individual or group concerns. Unit Managers will be responsible for monitoring compliance in this area.

7. Findings:
Children are not given the opportunity to participate in planning recreational activities with the staff.

- *One child stated that the Group Home staff only allows the residents to engage in sports activities. This child stated that he is not a physical activity type of person and would rather engage in activities like board games or non-physical type of activities.*

Root Case Analysis and Quality Improvement Plan:
In the past, a specific staff member created the Activity Schedule, which outlined the activities in which clients could engage on each day of the week. Unfortunately, however, these Activity Schedules did not account for the various needs of both the staff and the clients, which led to the staff members experiencing considerable difficulty with facilitating many of these activities. Additionally, while previous Activity Schedules have included various recreational, extracurricular, and community activities, many of these events did not occur due to a lack of consistent communication between the person/people in charge of creating the schedule and organizing the events, and those responsible for holding the events. Due to these difficulties, each previous Activity Schedule has been inconsistent and ineffective for both staff and clients.

Corrective Action Plan:
Comprehensive Activity Schedules will be produced in a weekly manner to ensure that clinical and recreational opportunities for clients are properly implemented and allow for

clients to meet in a town hall forum to provide input in regards to the recreational activities that they would like to be placed within future Activity Schedules within reason. Providing the clients with a "voice and choice" within the residential program will create greater participation and engagement from participants within the program. Unit Managers and the Clinical Administrative Team will be responsible for monitoring compliance in this area.

8. Findings:
Clients indicated not being given the opportunity to participate in recreational, extracurricular, and/or community activities.

- *Three of the children stated that the only after school program offered to residents is art therapy. Outside of that, there are no other such activities for residents to choose from.*

Root Case Analysis and Quality Improvement Plan:
In the past, a specific staff member created the Activity Schedule, which outlined the activities in which clients could engage on each day of the week. Unfortunately, however, these Activity Schedules did not account for the various needs of both the staff and the clients, which led to the staff members experiencing considerable difficulty with facilitating many of these activities. Additionally, while previous Activity Schedules have included various recreational, extracurricular, and community activities, many of these events did not occur due to a lack of consistent communication between the person/people in charge of creating the schedule and organizing the events, and those responsible for holding the events. Due to these difficulties, each previous Activity Schedule has been inconsistent and ineffective for both staff and clients.

Corrective Action Plan:
As part of the implemented comprehensive Activity Schedule, we added considerably more activities for the clients to choose from on a daily basis. Prior to this new Activity Schedule, we only had the following mental health groups: Seeking Safety, Aggression Replacement Therapy (ART), Strengthening Families (SF), and Art Therapy. Once we created the new Activity Schedule, we added the following groups to the four groups listed above: Matrix, Cognitive-Behavioral Interventions for Substance Abuse (CBI-SA), Life Skills, Dialectical-Behavioral Art Therapy, Expressive Dance, Piano, Ping Pong, Love, Sex, and Relationships, Laugh Therapy, Appreciating Sobriety, Relapse Process, Building a Garden, and Engagement.

In addition to considerably improving the amount of groups in which clients can participate, we also improved the policy in which they can join them. Specifically, prior

to the new Activity Schedule, a client could only enter a group within the first 2 weeks of the group starting, which put many clients at a disadvantage. Since the creation of the new Activity Schedule, clients are able to communicate to their therapists and unit staff leaders their desire to join any number of new groups at any time. Essentially, clients now have a much wider variety of choices of groups in which to participate, as well as, control over when they want to stop going to one group and join another group.

Further, we have connected with a variety of community organizations, including the National Alliance for Mental Illness (NAMI) and Hospitals and Institutions, whose group members speak about the message of Narcotics Anonymous. The new Activity Schedule includes speakers from NAMI presenting to the clients and staff for an hour on the first Wednesday of every month. Additionally, the new Activity Schedule includes speakers from Hospitals and Institutions speaking with the clients and staff every Thursday for one hour.

In terms of recreation, the old Activity Schedule did not ensure the clients consistently had at least one hour per day for recreation. The new Activity Schedule improves upon this in a variety of ways. First, each weekday from 3:30 pm to 4:30 pm, all of the clients engage in outdoor recreation. Second, each weekday between 7:00 pm – 8:30 pm, all of the clients have the option to work out in the weight room or go on a walk, all under staff supervision. Third, every Wednesday from 3:30 pm – 5:00 pm, we now have games and activities for both the clients and staff to engage in, as a way to promote fun, team-building, and cohesion. Fourth, on Saturdays from 3:30 pm – 5:00 pm, we now have an extended period of recreation time for the clients.

Lastly, while the previous Activity Schedule consisted of sporadic 1-3 hour time periods for outings, the new Activity Schedule includes 2 ½ hour periods on both Saturdays and Sundays solely for outings for the clients. We are still working on coordinating a process where on Sundays, the clients choose from 4 different outings they each want to attend for the following Sunday, a process that will further support clients' voice and choice. We expect this process to begin taking place by the end of June, 2017.

Please find enclosed a copy of the current Activity Schedule.

9. Findings:
Children indicated not being aware of their rights to refuse psychotropic medication

- *One client indicated that the staff would tell him that he cannot refuse his medication or he will be given a write up.*

Root Case Analysis and Quality Improvement Plan:
The reason for this noted deficiency is due to the treatment team member utilizing inappropriate techniques to educate or inform the client of the importance of taking psychotropic medications.

Corrective Action Plan:
Phoenix House Psychiatrists and Nursing team provides information and education to each client and minor-aged client's guardians, when the client is prescribed or is taking psychotropic medication. In addition, similar training will be provided to all members of the treatment team during monthly group supervision, which will include a client's individual health rights. Psychiatrists, Nursing, and Unit Managers will be responsible for monitoring compliance in this area.

VIII. Personal Needs/Survival and Economic Well-Being

1. Findings:
Clients indicated they were not provided with youth development or daily living skills services.

- *Child 2-Has talked with counselor about college and job corp. but no follow through by staff on his requests.*
- *Child 4-Has only been provided simple house chores.*

Root Case Analysis and Quality Improvement Plan:
Although youth development services are engrained within our residential program, targeted opportunities that highlight and coordinate the development of independent living skills from an intentional aspect have not been properly identified nor reflected within activity schedules and client charts.

Corrective Action Plan:
To ensure that youth at the facility are provided with opportunities to develop daily living skills and as part of our clinical transformation process, a collaborative effort between our Clinical Department and Residential Department will allow for weekly Activity Schedules to include structured opportunities for clients to obtain targeted independent living skills. Clinical Administrative Team will ensure that Daily Activity Schedules are updated, actively occurring, and facilitated by qualified staff members. Participation by individual clients will be reflected within individual charts located in our electronic health records.

Case Managers meets with their assigned clients on weekly basis and will ensure the information related to requests for outside services, such as applying to college or

enrolling into job corp., are documented in the Needs and Services Plan and in the Transition Plan. The Transition Plan is reviewed every 30 days to ensure the youth are provided with the linkages and support to access the services requested. Additionally, the treatment team meets twice a month for case conferences and the treatment team will utilize the Case Conferences to ensure the clients have received the services and support he/she needs to access the requested outside services. Unit Managers will be responsible for monitoring compliance in this area.

IX. Discharged Clients

1. Findings:
Discharge summary for one client does not align with the permanency plan indicated in the initial NSP.

- *Child #3--Initial NSP indicated that permanency plan was FR with father. However, discharge summary indicated that the child was transferred to a different GH within 2 months of placement. Contradictory.*

Root Case Analysis and Quality Improvement Plan:
Lack of coordination between the Clinical Department and Residential Department have led to failure to meet routinely and share information pertinent towards completed tasks related to client NSP's. Lack of oversight and direction by immediate supervisors to ensure that permanency planning is congruent with clinical expectations has also contributed to this matter.

Corrective Action Plan:
Assigned therapist from the Clinical Department have been tasked with providing Transition Plans and Discharge Summaries for all clients per our contract with DMH and as part of our clinical transformation will be providing this direct information to assigned case managers to ensure congruence and proper indications within the NSP. Case Conferences attended by the Clinical Supervisor, Unit Manager, assigned therapist and case manager will be held to ensure that documentation related to the permanency planning are aligned, comprehensive in nature, and entered in existing NSP's.

X. Personnel Files

1. Findings:
Staff educational/experience documentation were not on file.

- *Staff 1-Missing educational/experience docs. from file.*

Root Case Analysis and Quality Improvement Plan:
The responsibility to obtain proper documentation prior to beginning employment was not fulfilled by our Human Resources Department, resulting in new hires being assigned job duties without presenting all documentation needed to begin employment.

Corrective Action Plan:
Onboarding practices for new hires require for the HR Generalist, who has been assigned to perform specific duties towards collection of required documentation to add required documentation into employees Personnel Files prior to the new hire being allowed to perform work duties. The Human Resources Department has created a New Hire Onboarding Checklist that allows for greater clarity in regards to appropriate documentation needed to begin employment at the LVT site. New Hires within the onboarding process will not be permitted to begin actual employment with the agency until all required documentation is secured within individual Personnel Files.

Please find enclosed a copy of the New Hire Onboarding Checklist.

2. Findings:
Staff did not have current California driver's license on file.

- *Staff #1 & 2-CDL missing from file.*
- *Staff #3* & 4-Expired CDL on file.

Root Case Analysis and Quality Improvement Plan:
There was a change in the designated staff responsible for ensuring a current staff driver's license is on file and there was also turnover in Human Resources Department. As a result of these changes, there was a lack of follow up and accountability with staff.

Corrective Action Plan:
Phoenix House has centralized the monitoring of staff driver's license. Human Resource Department implemented a spread sheet on 03/01/2017 that is checked on a monthly basis for expired DL or ID. Human Resources Department will notify employee of expired DL/ID via email and phone call to phone number listed. Human Resources Department also notifies supervisor that the employee has until the end of the week to comply or the employee will be removed from weekly roster until they can provide valid DL or ID.

3. Findings:

Initial Training documentation for one staff was not on file.

- *Staff #4-Missing documentation from file of INITIAL training upon hire.*

Root Case Analysis and Quality Improvement Plan:

Previously, initial and annual training plans and its implementation was the sole responsibility of the program director. As such, the program director was responsible for coordinating trainings throughout the year in order to meet the contract and internal requirements. The completion of trainings was kept by the program administrator, who would track completion on an excel spreadsheet. In addition, online trainings were completed via a system called Relias. The completion of these trainings were captured in a report and sent to the appropriate supervisor. However, the completion tracking for online and in person trainings was never brought together by any one individual. This made the process of checks and balances cumbersome and accurate tracking difficult.

Corrective Action Plan:

The Initial Required Training checklist will be utilized with all new direct care staff to ensure all the required trainings are completed prior to the staff being left alone with clients and counted in the staff to child ratio. Until the initial 8 hours of training is completed, new direct care staff will be visually supervised at all times by direct care staff who have met the training requirements. The Initial Required Training checklist must be completed and signed off by the direct care staff, trainer, and direct supervisor to indicate that the staff has fully completed the required initial training. The direct supervisor will submit a copy of the signed checklist to QR to be uploaded and tracked in the Relias training system.

Please find enclosed a copy of the Initial Required Training checklist.

4. Findings:

One staff did not obtain the required 20 hours of ongoing training.

- *Staff #5-Only had 14.5 hrs recorded on file for previous year.*

Root Case Analysis and Quality Improvement Plan:
Previously, annual training plans and its implementation was the sole responsibility of the program director. As such, the program director was responsible for coordinating trainings throughout the year in order to meet the contract and internal requirements. The completion of trainings was kept by the program administrator, who would track completion on an excel spreadsheet. In addition, online trainings were completed via a system called Relias. The completion of these trainings were captured in a report and sent to the appropriate supervisor. However, the completion tracking for online and in

person trainings was never brought together by any one individual. This made the process of checks and balances cumbersome and accurate tracking difficult.

Corrective Action Plan:
Based on the findings of the probation audit of personnel files that there were training deficiencies, the Root Cause Analysis (RCA) team has determined the following corrective action to prevent a repeat of this incident:

Training tracking will be relocated to one place (Relias) and will be managed by the Quality Department. As such, the following steps will be followed:

1. The program director will submit an annual training plan to Quality Resources (QR) at the start of each fiscal year
2. QR will enter the training plan into Relias, and assign the training curriculum to all relevant Lake View Terrace staff.
3. QR and program director will coordinate/determine which trainings need to be done in person, and schedule trainings appropriately. All trainings entered into the Relias curriculum must have a due date or a date the training is to be held.
4. Trainings completed through Relias will be updated as "completed" automatically.

    a. For in person trainings, the Project Administrator will gather the signatures of all attendees and turn in the sign in sheet to QR (QR will upload sign in sheet and a copy of the power point/training material used and archive). For employees that attended the in person training, QR will manually mark "completed" in the employees Relias profile.

5. Trainings that an employee does not complete by the due date will be captured on a monthly report that is sent to the Program Director and employees supervisor. An additional report will be sent to the QR Director in order to ensure compliance.

    a. The supervisor will respond to the report with a plan of how/when the employee will complete their required training

The expected result of this corrective action is the elimination of human error associated with future scheduled trainings. We have purposefully created several QA checkpoints and simplified the tracking process so that it is easier to identify employees not meeting training requirements.