COUNTY OF LOS ANGELES
PROBATION DEPARTMENT

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

TERRI L. McDONALD
Chief Probation Officer

May 15, 2018

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: **HAYNES FAMILY OF PROGRAMS GROUP HOME CONTRACT COMPLIANCE MONITORING REVIEW**

The Department of Probation, Placement Permanency & Quality Assurance (PPQA), Group Home Monitoring (GHM), conducted a review of Haynes Group Home, operated by Haynes Family of Programs, in May 2017. Haynes has one (1) site, located in the Fifth Supervisorial District of Los Angeles County. Haynes provides services to Los Angeles County Probation foster children and Department of Children and Family Services (DCFS) foster children. According to Haynes' program statement, its purpose is to provide intensive mental health services, milieu treatment, and daily care to abused and troubled youth who have emotional and/or behavioral problems.

Haynes is a 36-bed site and is licensed to serve a capacity of 36 boys, 13-17 years of age, and Non-Minor Dependents. At the time of review, Haynes was serving 10 Probation children and 10 DCFS children. The overall length of placement was 14 months, and their average age was 16.2 years old. For the sample size, the placed children's overall average length of placement was four (4) months, and their average age was 16 years old.

Seven (7) children were randomly selected for the interview sample: four (4) Probation foster children and three (3) DCFS foster children. There were two (2) Probation foster children and two (2) DCFS foster children prescribed psychotropic medication, and those cases were reviewed for timeliness of Psychotropic Medication Authorizations and to confirm the required documentation of psychiatric monitoring. Additionally, five (5) discharged children's files, two (2) Probation and three (3) DCFS, were reviewed to assess compliance with permanency efforts. Five (5) staff files were also reviewed for compliance with Title 22 Regulation and County Contract Requirements.

SUMMARY

During the PPQA/GHM review, the interviewed children generally reported feeling safe at Haynes, that they were provided with good care and appropriate and effective services of quality, were comfortable in their environment, and were treated with respect and dignity. Haynes was in compliance with six (6) of the 10 areas of the Contract Compliance Review: Education and Workforce Readiness, Health and Medical Needs, Psychotropic Medication, Personal Rights and Social/Emotional Well- Being, Discharged Children, and Personnel Records.

PPQA/GHM noted deficiencies in four (4) of the 10 areas, with 10 deficient elements out of 76 specific elements within the 10 areas. Although, there were no egregious findings or child safety issues in any of the areas, the same deficiencies from the last review period were noted in two (2) of the 10 areas. In the area of "Facility and Environment," Haynes needed to make minor repairs to ensure that the common areas of the Group Home, as well as the children's bedrooms were well maintained. In the area of "Maintenance of Required Documentation and Service Delivery," Haynes failed to complete comprehensive Initial and Updated Needs and Services Plans (NSPs), as well as document on the NSPs counseling services provided to children.

New areas of deficiency were found in the area of "Licensure and Contract Requirements," in that, Haynes needed to ensure that vehicles that transport children remain in good repair. In addition, they were to ensure that monetary allowance logs, as well as clothing allowance logs were accurately maintained. Deficiencies were also noted in the area of "Personal Needs/Social and Economic Well-Being." Haynes needed to ensure that children were provided with necessary transportation services and that they encouraged and supported children with maintaining life-books.

REVIEW OF REPORT

On May 25, 2017, Probation PPQA Monitors Lori Tchakerian and Joseph Ninofranco held an Exit Conference with the following Haynes Administrators: President and Chief Executive Officer, Dan Maydeck; Senior Vice-President, Frank Linebaugh; Quality Assurance Coordinator, Joy Gahring; Director of Treatment Services, Tisha Langley; Director of Human Resources, Tiffany Burg; Campus Manager, Paul Watts; and Maintenance Supervisor, Douglas Henton. All Haynes Administrators agreed with the review findings and recommendations and were receptive to implementing systemic changes to improve their compliance with regulatory standards, as well as address the noted deficiencies in a Corrective Action Plan (CAP).

Haynes Group Home provided the attached approved CAP addressing the recommendations noted in this compliance report 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 Division.

Should you have any questions or require additional information, please contact Director Lisa Campbell-Motton, Placement Permanency and Quality Assurance, at (323) 240-2435.

TLM:SEM:FC
PV:tm

Attachments

c: Sachi A. Hamai, Chief Executive Officer
John Naimo, Auditor-Controller
Bobby Cagle, Director, Department of Children and Family Services
Public Information Office
Audit Committee
Sybil Brand Commission
Community Care Licensing
Latasha Howard, Probation Contracts
Dan Maydeck, Haynes Family of Program, President, and Chief Executive Officer

HAYNES FAMILY OF PROGRAMS GROUP HOME
CONTRACT COMPLIANCE MONITORING REVIEW SUMMARY

LICENSE NUMBER: 191501972
RATE CLASSIFICATION LEVEL: 12

	Contract Compliance Review	Findings: May 2017
I	**Licensure/Contract Requirements** (8 Elements)	
	1. The Group Home was free of any substantiated Community Care Licensing Division (CCLD) citations on child abuse/safety and/or physical deficiencies since the last review.	1. 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. Special Incident Reports (SIRs) documented in the Needs and Services Plans (NSPs) and case files and are properly reported via the ITrack system.	8. Full Compliance
II	**Facility and Environment** (5 Elements)	
	1. The exterior and the grounds of the Group Home are well maintained.	1. 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 appropriate recreational equipment and educational resources (e.g. computer) in good repair and makes them readily available to children.	4. Full Compliance
	5. The Group Home maintains adequate nutritious perishable and non-perishable food.	5. Full Compliance

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

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

	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.	8. Full Compliance 9. Full Compliance 10. Full Compliance 11. Full Compliance 12. Full Compliance 13. Full Compliance 14. Full Compliance 15. Full Compliance 16. Full Compliance
IX	**<u>Discharged Children</u>** (3 Elements) 1. The Group Home placed the child in accordance with their Program Statement and population criteria. 2. The Group Home discharged the child in accordance with the NSP permanency plan, or to a lower level of care. 3. The Group Home attempted to stabilize the child's placement prior to requesting a removal.	Full Compliance (ALL)
X	**<u>Personnel Records</u>** (14 Elements) 1. Staff signed a criminal record statement (LIC 508) prior to or on hire date. 2. Staff received criminal clearance from CCLD prior to hire date. 3. Staff received medical clearance within one year prior to hire date or within seven days after hire date. 4. Staff received tuberculosis (TB) clearance within one year prior to hire date or within seven days after hire date. 5. Staff met educational and/or experience requirements in accordance with the agency's Program Statement and Title 22 Regulations. 6. Staff signed the agency's policies, including confidentiality agreement and mandated reporter acknowledgment.	Full Compliance (ALL)

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

HAYNES FAMILY OF PROGRAMS (LEROY'S BOYS HOME) GROUP HOME
CONTRACT COMPLIANCE MONITORING REVIEW
FISCAL YEAR 2016-2017

SCOPE OF REVIEW

The purpose of this review was to assess Haynes Family of Programs (Haynes) Group Home's compliance with the County contract and State regulations and include a review of Haynes Group Home's program statement, as well as internal administrative policies and procedures. The monitoring review covered the following 10 areas:

- Licensure/Contract Requirements
- Facility and Environment
- Maintenance of Required Documentation and Service Delivery
- Educational and Workforce Readiness
- Health and Medical Needs
- Psychotropic Medication
- Personal Rights and Social Emotional Well-Being
- Personal Needs/Survival and Economic Well-Being
- Discharged Children
- Personnel Records

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

Five (5) staff files were reviewed for compliance with Title 22 Regulations and County contract requirements, and a site visit was conducted to assess the provision of quality care and supervision.

CONTRACTUAL COMPLIANCE

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

Licensure/Contract Requirements

An inspection was conducted of seven (7) Haynes Group Home vehicles that transport children. Of the seven (7) vehicles inspected, three (3) were not maintained in good repair. One (1) vehicle had torn upholstery in the first row of seats. The right side of the second vehicle was missing carpet and the left side of the other vehicle was missing paneling.

Seven (7) children's weekly allowance logs were reviewed. Of the seven (7) reviewed, one (1) was not accurately maintained in that, a child was missing $1.00 for the month of March since the addition on the weekly allowance log was completed incorrectly.

Seven (7) children's monthly clothing allowance logs were reviewed. Of the seven (7) reviewed, one (1) was not accurately maintained, in that the balance for the month of March was documented in the incorrect column.

Recommendation

Haynes Group Home management shall ensure that:

1. Vehicles that transport children are maintained in good repair.
2. Weekly allowance logs are accurately maintained.
3. Monthly clothing allowance logs are accurately maintained.

Facility and Environment

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

In the common area of Dow Cottage, two (2) window screens in the living room were torn and in need of replacement. In the common area of Burton Cottage, the downstairs bathroom had graffiti.

In Burton Cottage, Bedroom #4 had graffiti on the curtain and back door, and in Bedroom #5, there was graffiti on the bed. In Wittry Cottage, Bedroom #2 had graffiti on the bed frame and desk drawer, bedroom #4 had graffiti on the back door, and bedroom #6 had a tagging carved on the bedpost, as well as graffiti on the desk and back door.

Recommendation

Haynes Group Home management shall ensure that:

1. The common areas of the Group Homes are well maintained. This shall be in accordance with the Community Care Licensing, Title 22 Regulations, which states that all Group Home sites are to be "clean, safe, sanitary, and in good repair at all times."
2. The children's bedrooms of the Group Homes are well maintained. This shall be in accordance with the Community Care Licensing, Title 22 Regulations, which states that all Group Home sites are to be "clean, safe, sanitary, and in good repair at all times."

Maintenance of Required Documentation and Service Delivery

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

Of the seven (7) Initial NSPs reviewed, three (3) were not comprehensive, in that the Case-Plan Goal and/or Concurrent Case-Plan Goal was documented incorrectly. Two (2) of the Initial NSPs did not address why Adoption or Legal Guardianship were not options for the children, and on another, the Concurrent Case-Plan Goal was not completed. In addition, several Initial NSPs were not comprehensive, in that they did not contain Outcome Goals that were measurable and/or child specific.

Of the four (4) Updated NSPs reviewed, two (2) were not comprehensive, in that one (1) noted Family Reunification to a grandmother. In addition, both Updated NSPs did not address why Adoption or Legal Guardianship were not options for the children. One (1) Updated NSP did not include any Mental Health Clinical Visits information. There were three (3) Updated NSPs that were not comprehensive, in that Outcome Goals were the same as in the Initial NSPs, without any modifications documented, and none of the three (3) Updated NSPs were not child specific. In addition, an Outcome Goal was documented when a child had already achieved the goal. Lastly, one (1) Updated NSP contained signatures that were obtained more than five (5) days after the completion of the Updated NSP.

Four (4) of the children were missing documentation on their NSPs of counseling services, such as group counseling and/or anger management. It should be noted that Haynes Group Home provided the missing documentation after it was

brought to their attention to show that counseling services are provided to the children.

Recommendation

Haynes Group Home management shall ensure that:

1. Initial Needs and Services Plans are comprehensive, child specific, and completed accurately.

2. Updated Needs and Services Plans are comprehensive, child specific, and completed accurately.

3. Counseling services provided to children are documented on the Needs and Services Plans.

Personal Needs/Survival and Economic Well-Being

Seven (7) children were interviewed. During the interview process, one (1) of seven (7) children reported that he is not provided with transportation. It was reported that he was told by staff that because he is 18 years old, he has the responsibility to transport himself to school and work, since the transportation vehicles can only be used at specific times and that school and work are not in close proximity to Haynes Group Home. It was also reported that staff stated, "You are an adult. Take care of yourself."

Also, during the interview process, five (5) of seven (7) children reported that they did not receive life-books and that they are not aware of what life-books are.

Recommendation

Haynes Group Home management shall ensure that:

1. All children are provided with transportation.

2. All children receive life-books and that children are encouraged and supported by staff in keeping life-books.

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

PPQA/GHM's last compliance report dated November 30, 2016, identified five (5) recommendations.

Results

Based on the follow-up, Haynes Group Home fully implemented two (2) of the five (5) previous recommendations for which they were to ensure that:

- All children are provided with a variety of palatable meals and snacks.
- All County Worker's signatures authorizing implementation of the NSP are documented on the NSP.

However, this review discovered that Haynes Group Home failed to fully implement three (3) of the previous five (5) recommendations for which they were to ensure that:

- The physical deficiency cited in the common area be corrected and repaired in a timely fashion. In addition, the common areas are to be maintained daily. Even though Haynes Group Home repaired deficiencies cited from the previous year, there were deficiencies noted this year, as well.
- The physical deficiencies cited in the children's bedrooms are corrected and repaired in a timely fashion. In addition, the children's bedrooms are to be maintained daily. Even though Haynes Group Home repaired deficiencies cited from the previous year, there were deficiencies noted this year, as well.
- The Group Home treatment team develops comprehensive initial NSPs, with the participation of the developmentally age-appropriate child.

MOST RECENT FISCAL REVIEW CONDUCTED BY THE AUDITOR-CONTROLLER

A fiscal review of Haynes Group Home by the Auditor Controller has not been scheduled.

HAYNES
FAMILY OF PROGRAMS

Haynes Family of Programs
Leroy Boys Home
233 W. Baseline Road
La Verne, CA 91750
License Number: 191501972
Los Angeles County Probation Department
Group Home Monitoring Review
Corrective Action Plan
June 12, 2017

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

The following Corrective Action Plans (CAP's) requested on the Probation Group Home Monitoring Review Field Exit Summary dated 5/24/17 have been developed and implemented.

I. **Area of Review: Licensure/Contract Requirements**

Finding # 2

a) Vehicles used to transport children were not maintained in good repair.

- Vehicle: ripped upholstery in first row seat
- Vehicle: Missing carpet inside vehicle above wheel
- Vehicle: Missing side panel inside vehicle

Cause of Non-Compliance

- Vehicle: Tear in upholstery missed on routine maintenance check of vehicle
- Vehicle: Missing carpet on wheel well missed on routine inspection of vehicle fleet
- Vehicle: Missing side panel inside vehicle had just come off during transport immediately prior to inspection by the Group Home Monitor.

Corrective Action Plan

- Vehicle: Maintenance team members have been instructed to look for tears in upholstery during routine inspections. New seat cover was ordered and installed on 6/6/17.

- Vehicle: Maintenance team members have been instructed to look for torn or missing carpet during routine inspections. Torn area of carpet was removed, and area smoothed out and painted, as approved by Group Home Monitor. Repair completed on 6/5/17.

- Vehicle: Missing side panel inside vehicle was reinstalled immediately upon discovery of problem. Reinstalled on 5/22/17.

This plan has been implemented.

Plan to Maintain Compliance

Transportation Manager will conduct weekly inspections of all vehicles and report findings to the Director of Operations. Director of Operations will review those reports, and report directly to Senior Vice President weekly. Included in the report to Senior Vice President will be the plan to ensure all vehicles are maintained in proper condition following the results of the weekly inspections.

Person Responsible for implementation: Director of Operations, Transportation Manager

Finding # 6

Weekly allowance logs were not accurately maintained.

The addition was wrong on the Allowance Log of one (1) youth and he was missing $1 for the month of March.

Cause of Non-Compliance

Staff responsible for completing the allowance log made an error in addition.

Corrective Action Plan

Unit Manager will review all Allowance Logs Weekly to ensure all entries on the log are correct.

The youth whose allowance calculation was incorrect is no longer placed at our agency. The balance of $1 owed him was mailed to him via certified email, return receipt requested. See Addendum A for letter/proof of mail.

This plan has been implemented.

Person Responsible for implementation: Campus Manager

Finding # 7

Monthly clothing allowance logs were not accurately maintained.

The monthly clothing allowance log for one (1) youth had numbers in the wrong columns.

Cause of Non-Compliance

Staff responsible for completing the monthly clothing allowance log did not complete it correctly.

Corrective Action Plan

a) The Unit Manager will review all clothing allowance logs at the end of each month to ensure all entries on the log are correct.

b) The Clothing Allowance that was not completed correctly was revised to reflect correct information. See Addendum B for revised Clothing Allowance Log.

c) Staff in the unit were retrained on accurate completion of allowance logs, by Unit Manager on 6/7/2017. All other staff were formally retrained by QA Coordinator, on 8/30/2017.

d) If staff continue to fail to ensure accurate completion of allowance logs, they will be subject to discipline up to and including termination.

This plan has been implemented.

Plan to Maintain Compliance
Campus Manager will conduct bi-weekly audits of allowance logs to ensure that allowance logs are being maintained pursuant to the corrective action plan.

Person Responsible for implementation: Campus Manager

II. Area of Review: Facility and Environment

Finding # 10

Common quarters were not well maintained.

Dow Cottage

- Both screens in living room need replacement
- Burton Cottage: Downstairs bathrooms has graffiti

Finding # 11

Children's bedrooms were not well maintained

Burton Cottage

- Bedroom number 4 has graffiti on curtain and back door
- Bedroom number 5 has graffiti on the bed

Wittry Cottage

- Bedroom number 2 has graffiti on bed and desk drawer
- Bedroom number 4 has graffiti on back door
- Bedroom number 6 has a carving on the bedpost, graffiti on the desk and back door

Cause of Non-Compliance

Daily cottage inspection walkthrough conducted by Unit Manager failed to note graffiti and damage to window screens.

Corrective Action Plan

a) All graffiti was removed and window screens were replaced. Graffiti removed and window screens replaced 05/22/17.

b) Unit Managers will continue to conduct daily cottage inspection walkthrough and will follow-up immediately when graffiti is present or repairs of any kind are needed. Whenever possible, youth will be asked to remove graffiti, and when this is not possible, a notation will be made on the Maintenance Log regarding the need for graffiti removal.

c) The Campus Manager will conduct weekly cottage inspections, will note all areas of non-compliance with expected standards, and will require Unit Manager to correct safety deficiencies immediately and all other deficiencies within 24 hours.

d) The Program Services Manager will conduct a follow-up cottage inspection within 48 hours to ensure that all deficiencies have been corrected.

e) If a Unit Manager fails to ensure timely correction of any physical plant deficiencies, they will be subject to discipline up to and including termination.

This plan has been implemented.

Plan to Maintain Compliance

Senior Vice President will review cottage inspection forms that have been signed off by Campus Manager and Program Services Manager on a weekly basis.

Person Responsible for implementation:

Campus Manager and Program Services Manager

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

Finding # 14

The Initial NSP's were not completed accurately.

a) Case Plan and Concurrent Case Plan goals did not reflect plan for permanency.

b) Outcome goals were not formulated correctly and were not individualized.

Cause of Non-Compliance

a) Agency personnel did not have a clear understanding of the requirements for permanency on case plan and concurrent case plan goals.

b) Agency personnel did not have a clear understanding of the requirements for formatting outcome goals.

Corrective Action Plan

a) All personnel responsible for the completion of NSP's will be required to attend an NSP Training provided by the Probation Group Home Monitor. The NSP training took place on 7/13/2017. Staff in attendance were the: Unit Managers, Child Advocates, Therapists and QA Coordinator

b) The Campus Manager will ensure all Initial NSP's completed by Unit Managers and Child Advocates are completed correctly.

c) Ongoing noncompliance with the requirements for timely and accurate completion of Initial NSP's following the completion of NSP training will be reflected in the individual performance reviews of employees.

   Date employees were informed of discipline process: 12/26/2017

d) Employees who consistently fail to meet requirements for timely and accurate completion of Initial NSP's will be subject to discipline up to and including termination from employment.

   Date employees were informed of discipline process: 12/26/2017

e) The Quality Assurance (QA) Coordinator will continue to closely review all Initial NSP's and will consult with the Group Home Monitor as needed for support and training to ensure that the agency is compliant with the requirement for accurate completion of Initial NSP's.

This plan has been implemented

Plan to Maintain Compliance

Upon Completion of the NSP training, a scoring system will be implemented for NSP's. Quality Assurance Coordinator and Unit Manager will be responsible for using the scoring system to ensure on-going compliance of CAP.

Person Responsible for implementation:

QA Coordinator and Campus Manager

Finding # 15

The Updated NSP's were not completed timely.

a) Case Plan and Concurrent Case Plan goals did not reflect plan for permanency.

b) Outcome goals were the same as previous NSP without modification.

c) Outcome goal was already achieved.

d) NSP signatures by all required parties were completed late.

e) Outcome goals were not formulated correctly and were not individualized.

Cause of Non-Compliance

a) Agency personnel did not have a clear understanding of the requirements for permanency on case plan and concurrent case plan goals.

b) Agency personnel failed to modify goals that were not achieved.

c) Agency personnel failed to remove an achieved outcome goal from an NSP.

d) Agency personnel did not obtain NSP signatures timely.

e) Agency personnel did not have a clear understanding of the requirements for formatting outcome goals.

Corrective Action Plan

a) All personnel responsible for the completion of NSP's will be required to attend an NSP Training provided by the Probation Group Home Monitor. The NSP training took place on 7/13/2017. Staff in attendance were the: Unit Managers, Child Advocates, Therapists and QA Coordinator

b) The Campus Manager will ensure all Updated NSP's completed by Unit Managers and Child Advocates are completed correctly.

c) Ongoing noncompliance with the requirements for timely and accurate completion of Updated NSP's following the completion of NSP training will be reflected in the individual performance reviews of employees. Employees who consistently fail to meet requirements for timely and accurate completion of Updated NSP's will be subject to discipline, up to and including termination from employment.

d) The QA Coordinator will continue to closely review all Updated NSP's and will consult with the Group Home Monitor as needed for support and training

to ensure that the agency is compliant with the requirement for accurate completion of Updated NSP's.

This plan has been implemented

Plan to Maintain Compliance

All person's responsible for implementation of the CAP, QA Coordinator, Director of Treatment, Campus Manager, will conduct bi-weekly meetings to review NSP's to ensure those NSP's are meeting the standards set forth in the CAP.

Person Responsible for implementation:

QA Coordinator, Campus Manager, Director of Treatment and MH Program Manager

Finding #16

The group home did not provide children with counseling and other services (based on current NSP's):

a) There was no documentation on Mental Health Clinical Visits on updated NSP.

b) There was no documentation that multiple youth received counseling and other services, including anger management, group therapy, family therapy and tutoring.

Cause of Non-Compliance

a) The Therapist failed to document the completion of the assessment in the Mental Health Clinical Visit section of the Updated NSP.

b) The Therapist failed to document all the Mental Health Services provided in the Mental Health Clinical Visit section of the Updated NSP.

c) The Child Advocate and Unit Manager failed to document tutoring services or refusal of tutoring services on the Updated NSP.

Corrective Action Plan

a) All personnel responsible for the completion of NSP's will be required to attend an NSP Training provided by the Probation Group Home Monitor. The NSP training took place on 7/13/2017. Staff in attendance were the: Unit Managers, Child Advocates, Therapists and QA Coordinator

b) The Director of Treatment will ensure there is a plan for youth to receive all necessary mental health services, as identified as part of an individualized comprehensive mental health assessment completed at time of intake.

c) Therapists and the Mental Health (MH) Program Manager will conduct case review during weekly clinical group supervision to ensure that all youth are receiving all necessary mental health services, as determined by the individual treatment needs of each youth, identified during the assessment process or during Child and Family Team (CFT) or NSP meetings. These services are included but are not limited to individual therapy, group therapy, family therapy and rehabilitation services. Youth in need of substance abuse treatment will be referred to an outside agency that provides these services.

d) The Campus Manager and QA Coordinator will conduct weekly residential case review supervision meetings with Unit Managers and Child Advocates to ensure that all youth are receiving all necessary ancillary services including cottage Life Skills and Independent Living Skills Groups, tutoring, parenting classes and any other service needed as identified during the assessment process or during CFT or NSP meetings. "These services will be noted on the NSPs."

Date employees were informed of discipline process: 12/26/2017

This plan has been implemented

Plan to Maintain Compliance

Campus Manager will conduct weekly meetings with Unit Managers and Child Advocates to ensure all youth are receiving all necessary and ancillary services. Senior Vice President will also be responsible for ensuring that those weekly meetings are occurring as well. Campus Manager will report the results of those weekly meeting to Senior Vice President.

Persons Responsible for implementation:

QA Coordinator, Campus Manager, Director of Treatment, MH Program Manager

VIII. Area of Review: Personal Needs/Survival and Economic Well-Being

Finding #46

Children were not provided with transportation.

a) One (1) youth reported staff would not take him to work or school because he was 18 years old. The Needs and Services Plan(NSP) of the youth indicated staff would provide transportation to school and work.

Cause of Non-Compliance

Although the youth had approved community passes for developing independent living skills by demonstrating he could use public transportation, his NSP did not accurately reflect this plan.

Corrective Action Plan

a) All personnel responsible for the completion of NSP's will be required to attend an NSP Training provided by the Probation Group Home Monitor. The NSP training took place on 7/13/2017. Staff in attendance were: Unit Managers, Child Advocates, Therapists and QA Coordinator

b) The QA Coordinator will continue to review all NSP's to ensure they reflect the accurate plan approved by the treatment team and placement worker regarding transportation for youth to school and work. In general, the agency provides school and work transportation for all youth unless their individual treatment needs reflect that the youth needs to develop self-sufficiency skills by using public transportation or other means to go to school or work.

   Date employees were informed of discipline process: 12/26/2017

This plan has been implemented

Plan to Maintain Compliance

QA Coordinator will report to Senior Vice President weekly to ensure that the CAP is being implemented on an on-going basis.

Person Responsible for implementation: QA Coordinator

Finding # 47

Children were not encouraged and supported by staff in keeping a Lifebook.

a) Five (5) youth reported they did not receive Lifebooks.

Cause of Non-Compliance

The agency plan for all youth to work on Lifebooks was not effective and the agency did not have a system in place to document youth refusal to work on Lifebooks.

Corrective Action Plan

a) All youth will be provided a Lifebook at the time of intake. Staff will conduct a weekly Lifebook group activity and encourage all youth to participate. An attendance record will be maintained for all Lifebook groups and youth attendance or lack of attendance will be reflected on each youth's NSP.

   Date that youth signed for Life Books: 12/26/16

b) 30 scrapbook albums and scrapbooking supplies have been ordered. See Appendix C for receipt/proof of purchase.

This plan has been implemented.

Plan to Maintain Compliance

Campus Manager will provide a weekly report to Senior Vice President regarding life book group activities. Campus Manager will also review life books on bi-weekly basis with Unit Managers and youth to ensure that the CAP in implemented on an on-going basis.

Person Responsible for implementation: Campus Manager

Respectfully Submitted,

Daniel Maydeck
CEO/President