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July 8, 2016

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

FROM: Calvin C. Remington
Interim 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 Monitor(GHM), conducted a review of Phoenix House Group Home, operated by Phoenix Houses of Los Angeles, Inc., in December 2015. Phoenix House has one 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. 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 child 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 140-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 47 Los Angeles County Probation foster children and four (4) DCFS foster children. Based on the sample size, the placed children's overall average length of placement was three (3) months, and their average age was 16 years.

Seven (7) children were selected for the interview, four (4) Probation and three (3) DCFS. There were four (4) children in the sample who were prescribed psychotropic medication, one (1) Probation and three (3) DCFS, and those cases were reviewed for timeliness of Psychotropic Medication Authorizations (PMAs) and to confirm the required documentation of psychiatric monitoring. Additionally, five (5) discharged children's files, four (4)

Probation and one (1) DCFS, were reviewed to assess compliance with permanency efforts, and five (5) staff files were also reviewed for compliance with Title 22 Regulations and County Contract Requirements.

SUMMARY

During the PPQA/GHM review, the interviewed children generally reported feeling safe at Phoenix House, and that they were provided with good care and appropriate services, were comfortable in their environment and treated with respect and dignity. Phoenix House was in compliance with one (1) of the 10 areas of our Contract Compliance Review: "Psychotropic Medication".

PPQA/GHM noted deficiencies in nine (9) out of the 10 areas, and although there were no egregious findings or child safety issues in any of the areas, there was an increase in deficiencies from the previous year in four additional areas. In the five (5) repeated areas, some of the deficiencies are the same, while other elements were new this review period. In the area of "Licensure/Contract Requirements", Phoenix House needed to ensure that the fire extinguishers in the facility vehicles were in proper working condition and that the vehicles were clean and free of trash. In the area of "Facility and Environment", the children's personal rights were not posted in one of the units, and several of the children's bedrooms required minor repairs and graffiti removal. Overall, the facility is in good repair; however, bedroom furniture should be replaced. In the area of "Maintenance of Required Documentation and Service Delivery", two (2) of the children were missing required county worker authorization for Needs and Service Plans (NSPs), and the NSPs were not comprehensive. In the area of "Education and Workforce Readiness", one (1) of the children required Independent Living Program (ILP) services; however, the child reported that she was not receiving any services and the NSP did not have any documentation provided.

Deficiencies were also found in the area of "Health and Medical Needs", in that, one (1) of the children did not have a timely initial medical examination conducted and one (1) child had a late dental examination. In the area of "Personal Rights and Social/Emotional Well-Being", some of the children reported that their home passes are taken away from them as discipline for poor behavior, and one (1) of the children reported that outings are frequently cancelled due to staff shortages. In the area of "Personal Needs/Survival and Economic Well-Being", some of the children reported that they were not provided with Life Books, two (2) of which did not know what a Life Book was. In the area of "Discharged Children", one (1) of the children was not discharged according to his permanency plan because a "7-day" removal request was administered for failure to make sufficient progress in the placement program. Finally, in the area of "Personnel Records", one (1) of the staff files reviewed did not have medical clearances, and some of the staff files were also missing emergency intervention certifications and/or CPR/First Aid training.

REVIEW OF REPORT

On January 19, 2016, Probation PPQA Monitor Armando Juarez held an Exit Conference with Phoenix House Administration staff. Present at the conference was the Program Director, Dr. Frank Sanchez, Director of Operations, Erroll Small, Quality Assurance Director, Charity Wabuke, and Residential Program Quality Assurance Specialist, Sakineh Salmanpour. Dr. Sanchez and his Administrative staff agreed with the review findings and recommendations and they 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).

Phoenix House provided the attached approved CAP addressing the recommendations noted in this compliance report. A follow-up visit was conducted on March 30, 2016, to ensure that all deficiencies cited in the CAP have been corrected or systems put in place to avoid future deficiencies; however, due to repeated and additional deficiencies, an additional follow up will be conducted for all nine (9) deficient areas to ensure the agency's adherence to their CAP in these areas. Assessment for continued implementation of recommendations will be conducted during the next monitoring review.

A copy of this compliance report has been sent to the Auditor-Controller and Community Care Licensing.

If additional information is needed or any questions or concerns arise, please contact Director Lisa Campbell-Motton, Placement Permanency and Quality Assurance, at (323) 240-2435.

CCR:FC
LCM:ae

Attachments

c: Sachi A. Hamai, Chief Executive Officer
Lori Glasgow, Executive Officer, Board of Supervisors
John Naimo, Auditor-Controller
Phillip L. Browning, Director, Department of Children and Family Services
Public Information Office
Audit Committee
Sybil Brand Commission
Latasha Howard, Probation Contracts
Akilah Templeton, Phoenix Academy LVT Program Director
Community Care Licensing

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

License #: 191222731
Rate Classification Level: 12

	Contract Compliance Monitoring Review	Findings: December 2015
I	**Licensure/Contract Requirements** (9 Elements)	
	1. Timely Notification for Child's Relocation	1. Full Compliance
	2. Transportation Needs Met	2. Full Compliance
	3. Vehicle Maintained In Good Repair	3. Improvement Needed
	4. Timely, Cross-Reported SIRs	4. Full Compliance
	5. Disaster Drills Conducted & Logs Maintained	5. Full Compliance
	6. Runaway Procedures	6. Full Compliance
	7. Comprehensive Monetary and Clothing Allowance Logs Maintained	7. Full Compliance
	8. Detailed Sign In/Out Logs for Placed Children	8. Full Compliance
	9. CCL Complaints on Safety/Plant Deficiencies	9. Full Compliance
II	**Facility and Environment** (5 Elements)	
	1. Exterior Well Maintained	1. Full Compliance
	2. Common Areas Maintained	2. Improvement Needed
	3. Children's Bedrooms	3. Improvement Needed
	4. Sufficient Recreational Equipment/Educational Resources	4. Full Compliance
	5. Adequate Perishable and Non-Perishable Foods	5. Full Compliance
III	**Maintenance of Required Documentation and Service Delivery** (10 Elements)	
	1. Child Population Consistent with Capacity and Program Statement	1. Full Compliance
	2. County Worker's Authorization to Implement NSPs	2. Improvement Needed
	3. NSPs Implemented and Discussed with Staff	3. Full Compliance
	4. Children Progressing Toward Meeting NSP Case Goals	4. Improvement Needed
	5. Therapeutic Services Received	5. Improvement Needed
	6. Recommended Assessment/Evaluations Implemented	6. Full Compliance
	7. County Workers Monthly Contacts Documented	7. Full Compliance
	8. Children Assisted in Maintaining Important Relationships	8. Improvement Needed
	9. Development of Timely, Comprehensive Initial NSPs with Child's Participation	9. Improvement Needed
	10. Development of Timely, Comprehensive, Updated NSPs with Child's Participation	10. Improvement Needed

IV	**Educational and Workforce Readiness** (5 Elements)	
	1. Children Enrolled in School Within Three School Days	1. Full Compliance
	2. GH Ensured Children Attended School and Facilitated in Meeting Their Educational Goals	2. Full Compliance
	3. Current Report Cards Maintained	3. Full Compliance
	4. Children's Academic or Attendance Increased	4. Improvement Needed
	5. GH Encouraged Children's Participation in YDS/ Vocational Programs	5. Improvement Needed
V	**Health and Medical Needs** (4 Elements)	
	1. Initial Medical Exams Conducted Timely	1. Improvement Needed
	2. Follow-Up Medical Exams Conducted Timely	2. Full Compliance
	3. Initial Dental Exams Conducted Timely	3. Improvement Needed
	4. Follow-Up Dental Exams Conducted Timely	4. Full Compliance
VI	**Psychotropic Medication** (2 Elements)	
	1. Current Court Authorization for Administration of Psychotropic Medication 2. Current Psychiatric Evaluation Review	Full Compliance (ALL)
VII	**Personal Rights and Social/Emotional Well-Being** (13 Elements)	
	1. Children Informed of Group Home's Policies and Procedures	1. Full Compliance
	2. Children Feel Safe	2. Full Compliance
	3. Appropriate Staffing and Supervision	3. Full Compliance
	4. GH's efforts to provide Meals and Snacks	4. Full Compliance
	5. Staff Treat Children with Respect and Dignity	5. Full Compliance
	6. Appropriate Rewards and Discipline System	6. Improvement Needed
	7. Children Allowed Private Visits, Calls and Correspondence	7. Full Compliance
	8. Children Free to Attend or not Attend Religious Services/Activities	8. Full Compliance
	9. Reasonable Chores	9. Full Compliance
	10. Children Informed About Their Medication and Right to Refuse Medication	10. Full Compliance
	11. Children Free to Receive or Reject Voluntary Medical, Dental and Psychiatric Care	11. Full Compliance

	12. Children Given Opportunities to Plan Activities in Extra-Curricular, Enrichment and Social Activities (GH, School, Community)	12. Full Compliance
	13. Children Given Opportunities to Participate in Extra-Curricular, Enrichment and Social Activities (GH, School, Community)	13. Improvement Needed
VIII	**Personal Needs/Survival and Economic Well-Being** (7 Elements)	
	1. $50 Clothing Allowance	1. Full Compliance
	2. Adequate Quantity and Quality of Clothing Inventory	2. Full Compliance
	3. Children's Involved in Selection of Their Clothing	3. Full Compliance
	4. Provision of Clean Towels and Adequate Ethnic Personal Care Items	4. Full Compliance
	5. Minimum Monetary Allowances	5. Full Compliance
	6. Management of Allowance/Earnings	6. Full Compliance
	7. Encouragement and Assistance with Life Book	7. Improvement Needed
IX	**Discharged Children** (3 Elements)	
	1. Children Discharged According to Permanency Plan	1. Improvement Needed
	2. Children Made Progress Toward NSP Goals	2. Improvement Needed
	3. Attempts to Stabilize Children's Placement	3. Full Compliance
X	**Personnel Records** (7 Elements)	
	1. DOJ, FBI, and CACIs Submitted Timely	1. Full Compliance
	2. Signed Criminal Background Statement Timely	2. Full Compliance
	3. Education/Experience Requirement	3. Full Compliance
	4. Employee Health Screening/TB Clearances Timely	4. Improvement Needed
	5. Valid Driver's License	5. Full Compliance
	6. Signed Copies of Group Home Policies and Procedures	6. Full Compliance
	7. All Required Training	7. Improvement Needed

PHOENIX ACADEMY AT LAKE VIEW TERRACE
CONTRACT COMPLIANCE MONITORING REVIEW
FISCAL YEAR 2015-2016

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 Phoenix House'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 foster children were selected for the sample, four (4) Los Angeles County Probation and three (3) DCFS children. Placement Permanency & Quality Assurance (PPQA), Group Home Monitoring (GHM) interviewed each child and reviewed their case files to assess the care and services they received. At the time of the review, four (4) placed children were prescribed psychotropic medication, one (1) Probation and three (3) DCFS. 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 were reviewed, four (4) Probation and one (1) DCFS, to assess Phoenix House'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 nine (9) areas were out of compliance.

- Licensure/Contract Requirements
- Facility and Environment
- Maintenance of Required Documentation and Service Delivery
- Educational and Workforce Readiness

- Health and Medical Needs
- Personal Rights and Social Emotional Well-Being
- Personal Needs/Survival and Economic Well-Being
- Discharged Children
- Personnel Records

Licensure/Contract Requirements

During the inspection of all six (6) facility vehicles, three (3) had fire extinguishers that were expired and/or had accidentally discharged, and one (1) of the vehicles had graffiti on the back of the front passenger head rest. Therefore, Phoenix House was out of compliance with the section under "Vehicle Maintained In Good Repair".

Recommendation

Phoenix House management shall ensure that:

1. All facility vehicles used to transport children maintain all emergency equipment in proper working order at all times and maintain in compliance with Title 22 standards.

Facility and Environment

An inspection of the interiors and exteriors of Phoenix House revealed a deficiency in the common area and multiple deficiencies in the children's bedrooms that required correction.

- The common area of the Odyssey Unit did not have the children's personal rights posted in a visible area. As a result, Phoenix House was out of compliance with the section under "Common Areas Maintained".

- The bedroom areas also had some deficiencies that required attention. The following deficiencies were found in the Odyssey Unit Bedrooms: In Bedroom #216, the toilet was not working properly, in Bedroom #217, the entrance door was broken. In Bedroom #219, the window sill had graffiti and the entrance door handle was loose. In Bedroom #222, there was a dresser with a loose drawer, the bathroom in Bedroom #224, had a shower rail and a water knob that were both loose. In Bedroom #228, the entrance door lock was not secured. In Bedroom #240, there was a loose shower handle, Bedroom #241, had excessive graffiti inside of the closet, Bedroom #243, the entrance door handle and window had graffiti, and in Bedroom #245, the window and window sill had excessive graffiti.

The following deficiencies were found in the Genesis Unit Bedrooms: In Bedroom #202, the wall behind the entrance door had a hole and needs a door stop; additionally, the restroom had a strong urine odor. Bedroom #204 had excessive graffiti on the window and in Bedroom #205, the toilet area had excessive mildew. Bedroom #206 had a small hole in the wall near one of the beds. The restroom in bedroom #207 had urine odor, and in Bedroom #208, the entrance door handle was missing. Bedroom #252 also had urine odor coming from the restroom. Bedroom #253 also had urine odor and the shower rail was loose. The wall behind the entrance door to bedroom #254 had a hole and needs a door stop; additionally, the restroom also had urine odor. The following deficiencies were found in the Amethyst Unit (girls unit): Bedroom #49 had a toilet that was not working properly. Bedroom #60 had a damaged wall and had excessive graffiti on the dresser and hamper.

Overall, the facility is in good general shape; however, furniture in the bedrooms should be updated/replaced due to regular wear & tear. In addition, many of the bedrooms were dimly lit, and the male unit's bedrooms generally had excessive graffiti. As a result, Phoenix House was out of compliance with the section under "Children's Bedrooms Well Maintained".

Recommendation

Phoenix House management shall ensure that:

1. Children's personal rights are prominently posted in the common areas of the Group Home's living units at all times in order to maintain compliance with Title 22 standards.

2. The aforementioned cited deficiencies in the bedroom areas that have not already been fixed are corrected and repaired in a timely fashion, specifically a plan to permanently eliminate the urine odor from all aforementioned areas.

Maintenance of Required Documentation and Service Delivery

Seven (7) of the children's Needs and Services Plans (NSPs) were reviewed, and of those, only four (4) children were placed long enough to have an Updated NSP in their file. Therefore, only four (4) children had Updated NSPs reviewed, and seven (7) children had Initial NSPs reviewed. The following deficiencies were revealed:

- Two (2) of the children had Updated NSPs that were missing authorizing signatures by their county workers. In addition, the NSP's were not

properly documented, showing the Group Home's efforts to obtain such signatures. There were only dates provided with no indication of the types of attempts that were made. One (1) of the children had an Updated NSP with only one (1) attempt to obtain the county worker's signature documented and the attempt did not detail the progressive requests up to and including the Director/Regional Administrator. The other child's NSP had two dates provided, also with no detail as stated above. As a result, Phoenix House was out of compliance with the section under "County Worker's Authorization to Implement NSPs".

- A review of the children's Updated NSPs revealed that three (3) out of the four (4) children did not make sufficient progress. One (1) of the children's updated NSPs had an "Achieved Goals" section that contradicted the documented progress in other sections of the NSP. According to this section, the child had completed certain goals; however, other sections of the NSP indicated that the child had not made sufficient progress towards these same goals. Therefore, it was unclear if the achieved goals were fully achieved. Two (2) of the other children had goals that were not measurable; as a result, they also could not be assessed for progress. Phoenix House was out of compliance with the section under "Children Progressing Toward Meeting NSP Case Goals".

- During the review, one (1) of the four (4) children had one (1) updated NSP that did not have proper documentation on therapeutic services provided. The child's NSP was unclear as to why the child's aunt and/or mother were not more involved in family therapy sessions. The NSPs only indicated that the child had lived with her aunt prior to placement and that the child made telephone calls to her mother who lived out of state. However, the "NSP Treatment" section of the NSP indicated that Phoenix House would be providing the child with family therapy without indicating who specifically would be part of these family sessions. As a result, Phoenix House was out of compliance with the section under "Therapeutic Services Received".

- During the review, this same child's NSPs did not provide sufficient details on the Group Home's efforts to assist the child with important relationships. The NSPs only documented that the child was allowed to make regular telephone calls to her mother who lived out of state.

Phoenix House did not provide any other information on the status of this child's relationship with her biological mother or the efforts made by the Group Home to maintain this relationship. Additionally, the child was living with her aunt at one point, but the NSP did not indicate what the status of this relationship was or if the aunt was interested in being part of the child's life. As a result, Phoenix House was out of compliance with the section under "Children Assisted in Maintaining Important Relationships".

- During the NSP reviews, one (1) out of the seven (7) children had one (1) Initial NSPs that could not be assessed for timeliness. The NSP completion date was the same as the date of placement. As a result, it was unclear when the NSP was actually completed. The review also revealed that six (6) out of the seven (7) initial NSPs were not comprehensive. None of the children had Concurrent Case-Plans that were developed and established simultaneously with the main Case Plan Goal. Some of the initial NSPs had sections that either conflicted with one another, had dates or information that conflicted with information in the children's files, were missing information or were left blank. In addition, two (2) of these children's Initial NSPs had medical/dental exam dates that were not timely and failed to provide an explanation for the untimeliness. Five (5) out of the seven (7) initial NSPs did not have properly completed goals. The goals were either not developed using SMART guidelines or were missing specific goals to meet the needs of certain children. Some of the goals were incorrectly categorized, and others conflicted with one another. Finally, in general, the Initial NSPs had certain sections that did not appear to be case specific (i.e. "cookie cutter") such as, the "NSP Treatment" and the "Life Skills Training" sections. As a result, Phoenix House was out of compliance with the section under "Development of Timely, Comprehensive Initial NSPs with Child's Participation".

- Only four (4) out of the seven (7) children in the sample size had Updated NSPs. The Updated NSPs for these four (4) children were timely, but not comprehensive. They had many of the same issues as with the initial NSPs. There was conflicting information, missing or incomplete documentation, and incorrect dates and information provided. Three (3) updated NSPs that did not pursue the "Concurrent Case Plan" as identified in the initial NSPs and the quarterly update sections were left blank. None of the four (4) children had Updated NSPs with properly completed goals. The goals were either not developed using SMART guidelines, were not properly modified, and/or were missing specific goals

to meet the needs of individual children, and some were incorrectly categorized. In addition, it was unclear if goals were fully achieved because of conflicting information. Finally, as aforementioned in the assessment of the Initial NSPs, the Updated NSPs also had certain sections that appeared to be generic in nature and were not case-specific. As a result, Phoenix House was out of compliance with the section under "Development of Timely, Comprehensive Updated NSPs with Child's Participation".

Recommendation

Phoenix House management shall ensure that:

1. All efforts are made to obtain the county caseworker's signature of approval for all NSPs that are developed and the progressive requests up to and including the Director/Regional Administrator are documented. They shall also ensure that the signature pages for all NSPs properly document the Group Home's efforts to obtain the signatures for placed children and are made available for review upon request.

2. Each child's NSP is developed in a manner in which the goals are made attainable and measurable, so they can be assessed for the child's progress. Goals should also be clear and consistent throughout the entirety of each NSP that is developed in order to avoid ambiguous or contradictory NSPs.

3. Each child's NSPs is developed in that the therapeutic services provided are clearly identified and documented. This shall be done by ensuring that all relevant services that are to be provided are clearly documented in the NSPs, and that comprehensive updates are provided in the quarterly NSPs. This is to include specific "NSP Treatment" services being provided to the children's families as part of their reunification process.

4. Each child's Updated NSP documents the Group Home's efforts to assist the children in maintaining important relationships. This shall include, but not be limited to, documenting the efforts made in assisting the progress of family reunification, family finding efforts, and/or involvement of mentoring programs used for children that do not have any significant relationships.

5. Each child's Initial NSP is comprehensive. This shall be done by ensuring that the NSPs have accurate and detailed information throughout each NSP that is developed. This shall include, but not

limited to, accurate dates, as well as properly developed "Concurrent Case Plan Goals" sections with detailed information on the feasibility to return home, or the efforts made to find a suitable living arrangement for each child upon completion of the program. This shall also include the development of SMART "Outcome Goals" in accordance with the Master County Contract that are clear and specific to each child's needs.

6. Each child's Updated NSP is comprehensive. This shall be done by ensuring that the NSPs have accurate and detailed information, are properly updated, are case specific, and have all sections fully completed. This shall include, but not limited to, properly updated "Case Plan Goals" sections and "Concurrent Case-Plan Goals" sections with details on the progress and/or changes to their program. The "Outcome Goals" section of the NSPs shall also include proper documentation on goals that were fully achieved and/or modified and details are provided for any changes made and that they are developed using SMART guidelines in accordance with the Master County Contract.

Educational and Workforce Readiness

At the time of the NSP reviews for seven (7) children, assessment was also completed for school performance and vocational services. The following deficiencies were revealed:

- One (1) out of the seven (7) children did not have documentation of academic progress. The "Education" section of the updated NSP was unclear on the progress made and the "Outcome Goals" section did not have an educational goal to monitor the progress made. Therefore, it was unclear if this child made any academic progress. As a result, Phoenix House was out of compliance with the section under "Children's Academic or Attendance Increased".

- Two (2) out of the seven (7) children did not have appropriate documentation of the Youth Development Services (YDS) they received. Their NSPs were either unclear on the child's Independent Living Program (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 ILP services. As a result, Phoenix House was out of compliance with the section under "GH Encouraged Children's Participation in YDS/Vocational Programs".

Recommendation

Phoenix House management shall ensure that:

1. They establish educational goals in the children's NSPs that are specific and measurable, so that the children's progress can be assessed on a quarterly basis. In addition, the "Education" section of the NSPs shall have clear and specific updates on the children's progress that is consistent with the information of the "Outcome Goals" section of the NSPs.

2. They provide children with appropriate YDS services as part of their program, especially for children that are over the age of 16 and/or are expected to enter transitional housing upon graduation. The Group Home shall also ensure that they document all efforts to provide these services in each child's NSPs and that children are informed about these services and are part of the process.

Health and Medical Needs

A review of seven (7) children's files revealed the following deficiencies:

- Two (2) out of the seven (7) children did not have their initial medical examinations conducted within 30 days of placement. For one (1) of these children, the file indicated that the exam was conducted at their previous placement; however, the child's NSP indicated that it was completed at Phoenix House. The date in the NSP also conflicted with the date in the child's file. Therefore, it was unclear as to when this child was given an initial medical exam. The other child had the exam conducted 14 days late. As a result, Phoenix House was out of compliance with the section under "Initial Medical Exams Conducted Timely".

- One (1) out of the seven (7) children did not have proper documentation of their initial dental examination. This child's dental exam was conducted eight (8) days late. As a result, Phoenix House was out of compliance with the section under "Initial Dental Exams Conducted Timely".

Recommendation

Phoenix House management shall ensure that:

1. All children receive their initial medical examinations within 30 days of placement and that documentation is placed in each child's file and clearly documented in their NSPs. If they cannot be examined within the required timeframe then the Group Home shall document their efforts to comply with this standard.

2. All children receive their initial dental examinations within 30 days of placement and that documentation is placed in each child's file and clearly documented in their NSPs. If they cannot be examined within the required timeframe then the Group Home shall document their efforts to comply with this standard.

Personal Rights and Social/Emotional Well-Being

All seven (7) children were available and were interviewed at the Group Home and the issues were stated as follows:

- Three (3) of the seven (7) children indicated that the Group Home does not use a fair rewards and discipline system. Some of the female clients reported that when they are placed on "contract", as part of the discipline system, they do not get certain privileges; such as, going on home passes, family visits, or to wear make-up and style their hair. As a result, Phoenix House was out of compliance with the section under "Is a Fair Rewards and Discipline System in Place?"

- One (1) of the seven (7) children indicated that the Group Home does not always provide activities. The child reported that his recovery specialist frequently cancels group activities due to staffing shortages. As a result, Phoenix House was out of compliance with the section under "Children Given Opportunities to Participate in Extra-Curricular, Enrichment and Social Activities".

Recommendation

Phoenix House management shall ensure that:

1. They implement a discipline system that is in accordance with Title 22 standards as part of the children's personal rights. They shall also inform the children of these rights and ensure that staff are properly trained on acceptable forms of discipline.

2. They provide the children with socially enriching afterschool recreational and social activities, and that adequate staffing ratios are in accordance with Title 22 standards are followed, so as not to prevent child participation in said activities. In addition, each child's participation shall be properly documented in the children's files and NSPs.

Personal Needs/Survival and Economic Well-Being

All seven (7) children were available and were interviewed at the Group Home and the issues were stated as follows:

- Three (3) of the seven (7) children indicated that they did not have life books, two (2) of which indicated that they were not aware of their right to have them. As a result, Phoenix House was out of compliance with the section under "Encouragement and Assistance with Life Books".

Recommendation

Phoenix House management shall ensure that:

1. Upon entry into the program, children are given life books and are aware of their right to have them. They shall also ensure that the encouragement of the use of life books is included as part of their program.

Discharged Children

A review of five (5) discharged children's files was conducted and the following deficiencies were revealed:

- One (1) out of the five (5) children was not discharged according to their permanency plan. The child was removed from the facility on a "7-day" removal request for failure to make significant progress in their drug rehabilitation and sobriety. As a result, Phoenix House was out of compliance with the section under "Children Discharged According to Permanency Plan".

- One (1) out of the five (5) children did not make significant progress in the program. As aforementioned, this child was removed from the facility on a "7-day" removal request for failure to make significant progress in their drug rehabilitation and sobriety. As a result, Phoenix House was out of compliance with the section under "Children Made Progress Toward NSP Goals".

Recommendation

Phoenix House management shall ensure that:

1. They make all efforts to assist all children placed in their program in completing successful programs so that they may graduate and be

discharged in accordance with their permanency plan. They shall also ensure that they clearly document all efforts made by the Group Home in each child's NSPs.

2. They make all efforts to assist all children placed in their program in making sufficient progress so that they may graduate and transition out of the Group Home. They shall also ensure that they clearly document all efforts made by the Group Home in each child's NSPs.

Personnel Records

A review of five (5) staff files was conducted and the following deficiencies were revealed:

- One (1) out of the five (5) staff was missing proof of medical clearances prior to employment from their file. As a result, Phoenix House was out of compliance with the section under "Employee Health Screening/TB Clearances Timely".

- Three (3) of the five (5) staff in the sample size did not have all of the required training documentation in their files. Two of the staff files were missing the Pro-ACT training certificate. The other staff had an expired CPR certificate and did not have any on-going training documented in their file. As a result, Phoenix House was out of compliance with the section under "All Required Training".

Recommendation

Phoenix House management shall ensure that:

1. All staff have adequate proof of their medical clearances placed in their files and make them available for review upon request.

2. All staff have proof of all required training placed in their files and maintain updated records at all times. This shall include, but not be limited to, proof of current emergency intervention training and certification that can be verified, first-aid and CPR certification, as well as the required 20 hours of on-going training.

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

PPQA/GHM's last compliance report dated August 17, 2015 identified nine (9) recommendations.

Results

Based on the follow-up, Phoenix House fully implemented four (4) of the nine (9) previous recommendations for which they were to ensure that:

- Comprehensive and accurate allowance logs are consistently and permanently maintained and include staff's signatures, children's signatures.

- Their contact with the County Workers are documented monthly and maintained in the case files.

- All children were provided with timely follow-up medical examinations.

- Children prescribed psychotropic medication had completed court authorizations placed in their files.

Based on the follow-up, Phoenix House did not implement five (5) of the nine (9) previous recommendations for which they were to ensure that:

- Physical deficiencies to the common areas were corrected and repaired in a timely fashion, which included the posting of children's personal rights in the Amethyst unit. This is the second year in a row that the Group Home is deficient for failing to have the personal rights posted. As aforementioned under the area of "Facility and Environment" in this year's report, the common area of the Odyssey Unit did not have the children's personal rights posted in a visible area.

- Physical deficiencies to the children's bedrooms were corrected and repaired in a timely fashion. This included damage in the restrooms and to the furniture. As aforementioned under the area of "Facility and Environment" in this year's report, there were similar deficiencies in this year's review. In addition, there was also a large amount of graffiti in the bedrooms and several of the bedroom restrooms had strong foul odors.

- They developed timely and comprehensive Initial NSPs. In last year's review they were found deficient because they had sections that were not fully completed or were missing information. The NSPs were also missing comprehensive "Concurrent Case Plan" sections. As aforementioned under the area of "Maintenance of Required Documentation and Service Delivery" in this year's report, there were several similar deficiencies found. Some of the initial NSPs were missing detailed information for the "Concurrent Case-Plan Goal" sections and updated information such as family involvement and/or family finding efforts. In addition, the "Outcome

Goals" section of their initial NSPs were not properly developed because they did not use the SMART guidelines. For full details, please refer to the corresponding section of this report.

- They developed timely and comprehensive Updated NSPs. In last year's review they were found deficient because some of the children in the sample size had updated NSPs that were not properly updated. In addition, the "Outcome Goals" sections were not properly updated and/or modified. As aforementioned under the area of "Maintenance of Required Documentation and Service Delivery" in this year's report, there were similar deficiencies found. They were missing detailed information for the "Concurrent Case-Plan Goal" sections of the NSPs. The "Outcome Goals" section were also not properly developed because they did not use the SMART guidelines and were missing additional case-specific goals for the children. For full details, please refer to the corresponding section of this report. In addition, there was contradictory information throughout some of the NSPs and unclear goals in the "Achieved Goals" sections.

- All children were provided with thorough initial dental examinations within 30 days of admission. In last year's review they were found deficient because two (2) of the seven (7) children in the sample size had their initial dental examination conducted late. As aforementioned under the area of "Health and Medical Needs" in this year's report, one (1) of the children did not have their initial medical examination conducted timely. The exam was conducted eight (8) days late.

MOST RECENT FISCAL REVIEW CONDUCTED BY THE AUDITOR-CONTROLLER

A fiscal review of Phoenix House was completed by the Office of Auditor-Controller in the 2014-2015, fiscal review period; however, the report has not been posted on the website to date.

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Phoenix House
Rising Above Addiction

Frank Sanchez, LMFT, Ph.D.
Managing Director, Phoenix House
11600 Eldridge Ave.
Lake View Terrace, CA 91342

February 18, 2016

Deputy Probation Officer Armando Juarez, DPOII
And Probation Department Managers
Group Home Monitoring Unit
Placement Services Bureau
Lynwood Regional Justice Center
11701 S. Alameda St. 2nd Floor
Lynwood, CA 90262

Re: Group Home Corrective Action Plan Review Phoenix House Academy of Los Angeles

Dear DPO Juarez,

Please find attached the response and corrective action plans to the monitoring review field exit summary on January 19, 2016. I have met with the managers and directors at Phoenix House to review and address all findings. Our team will be utilizing our quality assurance process to support the efforts to improve our systems for compliance in all of these areas.

We will use this opportunity to continue to improve our services to the youth that Los Angeles County Probation Department has placed in our care. Thank you for your efforts and partnership.

Should you have any questions regarding the responses feel free to give me a call.

Sincerely,

Frank Sanchez, Ph.D., Managing Director
Phoenix House Academy Los Angeles
Phone: (821) 686-3272 ext. 4272

PHOENIX HOUSE GROUP HOME

CORRECTIVE ACTION PLAN

February 18, 2016

I. Licensure/Contract Requirements

Findings:

1. Three (3) facility vans had fire extinguishers that were expired and/or had accidentally discharged, and one (1) of the vehicles had graffiti on the back of the front passenger head rest.

Corrective Action Plan:

A. Phoenix House shall ensure that all agency vehicles in which children are transported in are within good repair by adhering to Phoenix Houses of California Policies and Procedures related to transportation. Prior to transporting clients in agency vehicles, staff members are expected to perform a documented Pre-trip Inspection to determine the physical and operational condition of the vehicle. In the event that the vehicle is deemed inoperable or not meeting criteria to safely transport clients in our care, specific information noting the issues will be made within the Pre-Trip Inspection documentation per policy, vehicle taken out of transportation rotation and scheduled for maintenance.

- Vehicle #1 trash within the vehicle cleaned and discharged fire extinguisher replaced. Strap to secure fire extinguisher mounted 12/16/15
- Vehicle #4 fire extinguisher replaced and expired fire extinguisher removed to the maintenance shop and tagged "out of service" 12/16/15. Strap to secure fire extinguisher mounted 12/16/15
- Vehicle #7 fire extinguisher replaced and discharged fire extinguisher taken to maintenance shop and tagged "out of service". Strap to secure fire extinguisher mounted 12/16/15
- Vehicle #8 cleaned and graffiti on back of front passenger headrest removed and cleaned 12/17/15

Root Cause Analysis and Quality Improvement Plan - Vehicles deemed deficient during the course of LA County Probation Audit derive from a failure of Phoenix House transporting staff to properly inspect the vehicle before and after each use, as outlined within Pre-Trip Inspection document to identify and rectify issues related to agency vehicles (graffiti, trash, faulty fire extinguishers). Another factor towards this deficiency include a failure of assigned staff members within the Transportation Department not properly noting

and removing un-fastened fire extinguishers to prevent discharges and removal of expired fire extinguishers. A quality measure in addition to the Pre-Trip Inspection will be weekly inspections of each vehicle by the assigned driver as well as well as a monthly inspection by the assigned Facility Manager. A new policy will be developed outlining this process by March1, 2016

II. Facility & Environment

Findings

1. The common area of the Odyssey Unit did not have the children's personal rights posted in a visible area.

2. The bedroom areas had deficiencies that required attention. The following deficiencies were found in the bedroom areas of the units:

Odyssey Unit

- Room #216-The toilet was not working properly.
- Room #217-The entrance door was broken.
- Room #219-The window sill had graffiti and the entrance door handle was loose.
- Room #222-Had a dresser with a loose drawer.
- Room #224-Bathroom had a shower rail and a water knob that were both loose.
- Room #228-The entrance door lock was not secure.
- Room #240-Had a loose shower handle.
- Room #241-Had excessive graffiti inside of the closet.
- Room #243-The entrance door handle and window had graffiti.
- Room #245-The window and window sill had excessive graffiti.

Genesis Unit

- Room #202-The wall behind the entrance door had a hole (needs door stop) and the restroom had a strong urine odor.
- Room #204-Had excessive graffiti on the window.
- Room #205-The toilet area had excessive mildew.
- Room #206-Had a small hole in the wall near one of the beds.
- Room #207-The restroom had a urine odor.
- Room #208-The entrance door handle was missing.
- Room #252-Aiso had a urine odor coming from the restroom.
- Room #253-Aiso had a urine odor and the shower rail was loose.
- Room #254-The wall behind the entrance door had a hole (needs door stop) and the restroom also had a urine odor.

Amethyst Unit

- Room #49-Had a toilet that was not working properly.
- Room #60-Had a damaged wall and had excessive graffiti on the dresser and hamper.

Overall, the facility is in good general shape; however, furniture in the bedrooms appears worn due to regular wear & tear. In addition, many of the bedrooms were dimly lit, and the bedrooms in the male units generally had excessive graffiti.

Corrective Action Plan:

1. Phoenix House shall ensure that all clients have visible access to Personal Rights (Title XXII) posted on individual units to ensure their knowledge and understanding. Odyssey Unit has posted Personal Rights (Title XXII) on two separate poster boards on opposite ends of the unit, where clients have immediate visible access. Work Order submitted and completed 12/16/15.

2. Phoenix House shall ensure that all common quarters of the facility are maintained by effectively monitoring client bedrooms, bathrooms and unit lounges to quickly determine items that may need repair and may pose as a danger to clients or staff members. Staff members are expected to follow maintenance protocols by submitting maintenance requests directly to Maintenance Supervisor and securing potentially hazardous materials or damaged areas that could pose a risk to clients and staff members
   - Odyssey-
     - #216 Toilet not working- Work Order submitted 12/16/15 and successfully Completed 12/17/15
     - #217 Entrance door broken- Work Order submitted 2/16/15 and successfully Completed 12/17/15
     - #219 Window Sill graffiti, entrance door handle loose- Work Order submitted 12/16/15 and successfully completed 12/17/15
     - #222 Dresser drawer loose- Work Order submitted 12/16/15 and successfully completed 12/17/15
     - #224 Shower rail and water knob loose- Work Order submitted 12/16/15 and successfully completed 12/17115
     - #228 Entrance door lock not secure- Work Order submitted 12/16/15 and successfully completed 12/17/15
     - #240- Shower handle loose- Work Order submitted 12/16/15 and successfully completed 12/17/15
     - #241- Closet had excessive graffiti- Work Order submitted 12/16/15 and successfully completed 12/17/15
     - #243- Entrance door handle and window had graffiti- Work Order submitted 12/16/15 and successfully completed 12/17/15
     - #245- Window and window sill had excessive graffiti- Work Order submitted 12/16/15 and successfully completed 12/17/15

- Genesis-
    - #202- Wall behind entrance door had a hole (needs door stop) and restroom had urine odor- Work Order submitted 12/16/15 and successfully completed 12/17/15
    - #204- Window had excessive graffiti- Work Order submitted 12/16/15 and cleaning of the window sill completed 12/17/15. Window has been cleaned, but may need to be replaced, as scratches remain visible on the glass
    - #205- Toilet area had excessive mildew- Work Order submitted 12/16/15 and successfully completed 12/17/15
    - #206- Small hall in the wall near bed-Work Order submitted 12/16/15 and successfully completed 12/17/15
    - #207- Restroom had urine odor- Work Order submitted 12/16/15 and successfully completed 12/17/15
    - #208- Entrance door handle missing-Work Order submitted 12/16/15 and successfully completed 12/17/15
    - #252- Restroom has urine odor- Work Order submitted 12/16/15 and successfully completed 12/17/15
    - #253- Restroom had a urine smell and shower rail was loose- Work Order submitted 12/16/15 for both items. Urine smell successfully completed and 2/2/16
    - #254- Wall behind entrance door had a hole (needs a doorstop)-Work Order submitted 12/16/15 and successfully completed 2/2/16. Restroom had a urine smell Work Order submitted 12/16/15 and successfully completed 12/17/15

- Amethyst-
    - #249 Toilet not working properly- Work Order submitted 12/16/15 and successfully completed 12/17/15
    - #60 Damaged wall and excessive graffiti (dresser hamper)- Work Order submitted 12/16/15 and successfully completed 12/17/15

Phoenix House is currently working with our corporate office to make updates to furniture throughout client bedrooms and common areas to replace identified furniture needing to be replaced due to wear and tear. Some clients have requested dimmer lighting in their bedrooms for therapeutic reasons and have been provided with the option of obtaining a desk lamp if additional lighting is needed.

Root Cause Analysis and Quality Improvement Plan - During the course of the walk through of the Odyssey Unit (boys) it was noticed by the LA County Probation auditor that only the first page of the Clients Personal Rights (Explanation Page) was posted on a bulletin board. Unit leadership failed to recognize that only the Explanation page of the Personal Rights for Children's Residential Facilities was posted without the additional second page that outlines the actual description of Personal Rights of children in our care. Although clearly stating that a "Copy of Client Rights" be posted in accordance with our agency's protocol of staff utilizing our established daily Unit Inspection Checklist to ensure compliance with CCL regulations, Director of Operations will augment Unit Inspection Checklist to specify that both the Explanation Page and list of Personal Rights page be posted on all unit bulletin boards. Various rooms and

Common areas deemed deficient during the course of the LA County Probation Audit derive from insufficient daily room inspections by unit staff members and failure to hold clients accountable. Phoenix House staff members are aware of the importance of assisting clients with strengthening their independent living skills. Efforts are underway to retrain staff in the use of more effective methods. The facility is incorporating a system of peer and staff monitoring into the current facility program. The new system will involve the use of checklists designed to identify problems in the aforementioned areas specifically unit cleanliness and the posting of personal rights.

Reference: Amended 6-14-16 Facility and Environment

Please see below for a detailed plan of action related specifically to the "Urine Odor/Smell" referenced in this Section.

Deficiency:

Rooms 202, 207, 252, 253, and 254 were found to have a "urine odor/smell." The facility is deficient as it relates to the section "Children's Bedrooms Well Maintained."

Corrective Action/Acknowledgement of Deficiency:

A subsequent walk-through of the facility revealed that there was a urine smell/odor coming from rooms 202, 207, 252, 253, and 254.

On 12-16-15 a Maintenance Request/Work Order was submitted to identify the source of the smell. Maintenance Requests/Work Orders are part of Phoenix Houses' internal system for addressing problems usually handled by maintenance. Employees and residents can submit Maintenance Request/Work Order forms at any time. Maintenance reviews the forms within 24 hours of receipt and begins the process of investigating/resolving the problem. In response to the request submitted to address the urine smell, maintenance researched the possibility of plumbing/sewage problems. None were found. The investigation revealed that the urine smell was caused by the following:

- Children urinating around the toilet and on the walls.
- Insufficient cleaning of the areas around the toilet and/or the chemicals being used did not eliminate the odor.
- In cases where the children did not clean the area properly facility staff did not complete the task completely. While the area appeared clean, the odor remained.
- Heavy duty GI (general inspection) cleanings were inadequate. There was a need to clean the *corners*, walls etc. and not just the area surrounding the toilet.
- Daily/weekly inspections were not being completed as often as is required per Phoenix House policy and if they were, problem areas were not adequately addressed.
- Children required more training/support as it related to making gains in the area "Independent Living Skills."

In response to the aforementioned findings, the following occurred:

- 12-17-15 the children and facility staff participated in a deep cleaning exercise with the assistance and supervision of facility maintenance staff.
- Following the initial clean-up, facility maintenance staff used an enzyme cleaner designed to sanitize areas saturated with urine and eliminate the associated smell.
- Several subsequent House Meetings were held to address the issue with the children on the units. The topic is also addressed more thoroughly in the Life Skills /Independent Living skills group.
- By June 1, 2016 the facility re-introduced job functions, stipends, and a rewards system that had previously been replaced with an intervention that did not yield the results hoped for. Children are responding well and the units are cleaner.
- By June 1, 2016 Unit Leaders and maintenance staff were retrained and advised that they are to complete GI cleanings and address smells/odors when they are not properly addressed during job functions/chores.
- By June 1, 2016 Unit Leaders and maintenance staff were retrained and advised that they are required to mop the floors 2 times per day, once in the morning and once in the late afternoon/evening.
- On June 2, 2016, a 2 hour training was held with unit leadership to review protocols meant to ensure a clean and safe environment. A subsequent meeting/training was held with the children on the units and the unit staff on the same day.

On a go-forward basis the facility will adhere to the following:

- The Unit Inspection Checklist will be completed each shift and deficiencies documented and addressed within 24 hours. Addressing a deficiency means correcting it before the end of shift or advising the next shift that the deficiency needs to be corrected, and when applicable, submitting a Maintenance Request/Work Order to address problems requiring repair by a third party.
- The children will participate in general cleaning daily. Facility staff will clean areas not adequately cleaned by the children.
- Units will be mopped twice daily, once in the morning and once in the late in the afternoon by facility staff.
- GI (General Inspection) deep cleanings will happen every Saturday with the assistance and supervision of facility staff and maintenance.
- The urine smell will be addressed/discussed monthly during the facility Health and Safety meeting for the next 6 months. This will ensure that the problem is under constant review.
- Children will receive ongoing support and guidance as it relates to hygiene, and proper bathroom habits. Specifically, the topic will be reviewed weekly in one or more of the following ways: group intervention, individual counseling, job functions/chores, specialized groups, house meetings, and/or one to one coaching.

III. Maintenance of Required Documentation and Service Delivery

Findings:

1 Two (2) of the children had NSPs that were missing authorizing signatures by their county workers. In addition, the NSP's did not properly document the Group Home's efforts to obtain such signatures. One of the children had an updated NSP with only one (1) attempt documented.

2. According to the updated NSPs, three (3) out of the four (4) children did not make sufficient progress. One of the children's updated NSP had an "Achieved Goals" section that contradicted with documented progress in other sections of the NSP. According to this section, the child had completed certain goals; however, other sections of the NSP indicated that the child had not made sufficient progress towards these same goals. Therefore, it was unclear if the achieved goals were fully achieved. Two of the other children had goals that were not measurable; as a result, they also could not be assessed for progress.

3. One (1) of the four (4) children with updated NSPs did not have proper documentation on therapeutic services provided. The child's NSPs were unclear on why the child's aunt and/or mother were not more involved in family therapy sessions. The NSP only indicated that the child lived with her aunt prior to placement and that the child made telephone calls to her mother who was living out of state. However, the "NSP Treatment" section of the NSP indicated that Phoenix House would be providing the child with family therapy without indicating who specifically would be part of these family sessions.

4. The same child's NSPs did not provide sufficient details on the Group Home's efforts to assist the child with important relationships. The NSPs only documented that the child was allowed to make regular telephone calls to her mother who lived out of state. Phoenix House did not provide any other information on the status of this child's relationship with her biological mother or efforts made by the Group Home to maintain this relationship. Additionally, the child was living with her aunt at one point, but the NSP did not indicate what the status of this relationship was or if the aunt was interested in being part of the child's life.

5. One (1) out of the seven (7) children had an initial NSP that could not be assessed for timeliness. The NSP completion date was the same as the date of placement. As a result, it was unclear when the NSP was actually completed. The review also revealed that six (6) out of the seven (7) initial NSPs were not comprehensive. None of the children had Concurrent Case-Plans that were developed and established simultaneously with the main Case Plan Goal. Some of the initial NSPs had sections that either conflicted with one another, had dates or information that conflicted with information in the children's files, or were missing information or left blank. In addition, two (2) of these children's NSPs had exam dates that were not timely and failed to provide an explanation for the untimeliness. Five out of the seven (7) initial NSPs did not have properly completed goals. The goals were either not developed using SMART guidelines or were missing specific goals to meet the needs of certain children. Some of the goals were incorrectly categorized, and others conflicted with one another other. Finally, in general, the NSPs had certain sections that did not appear to be case specific (ie "cookie cutter") such as the "NSP Treatment" and the "Life Skills Training" sections.

6. The quarterly NSPs were timely, but not comprehensive. They had many of the same issues as with the initial NSPs. There was conflicting information, missing or incomplete documentation, and incorrect dates and information provided. Three of these children had updated NSPs that did not pursue the "Concurrent Case Plan" as identified in the initial NSPs and the quarterly update sections were left blank. None out of the four (4) children had updated NSPs with properly completed goals. The goals were either not developed using SMART guidelines, were not properly modified, and/or were missing specific goals to meet the needs of certain children, and some were incorrectly categorized. In addition, it was unclear if goals were fully achieved because of conflicting information. Finally, as aforementioned in the assessment of the initial NSPs, the quarterly NSPs also had certain sections that appeared to be generic in nature and were not case-specific.

Corrective Action Plan:

1. Phoenix House is committed to the development of agency Case Managers assigned client caseloads and addressed the deficiency of not obtaining authorized signatures for county workers first as part of our scheduled Quality Records and Service Utilization Committee on 1/14/16. In the meeting a plan was devised on how to best support the process of obtaining county worker signatures and best practice of documenting efforts if unable to make direct contact with county workers. This process was further discussed in a Case Manager training held 2/16/16 and facilitated by Quality Assurance personnel.

2. Phoenix House is committed to the development of agency Case Managers assigned client caseloads and addressed the deficiency of not providing sufficient client progress towards goals within Needs and Services Plan by identifying the issue within our Quality Records and Service Utilization Committee meeting 1/14/16 to better understand how support in this area can be directly provided to Case Managers. A formal training for Case Managers in regards to better utilizing the SMART format in relation to creating comprehensive NSP's was conducted on 2/16/16 as part of the LA Probation Audit review. A scheduled formal training with DPO Juarez of LA County Probation Department was held 2/25/16 to review the SMART goal format and best practices towards constructing fluid and comprehensive NSP's.

3. Phoenix House is committed to the development of agency Case Managers assigned client caseloads and addressed the deficiency of clearly defining therapeutic services provided for clients in treatment within our Quality Records and Service Utilization Committee meeting on 1/14/16. Committee members further identified the need for better communication between clinical team members to ensure that therapeutic services that are provided to individual clients are congruent with information being discussed within treatment team meetings and individual meetings with client's assigned therapist and case manager. A training for Case Managers was held 1/14/16 to discuss the importance of creating comprehensive documentation within Treatment Section of NSP that properly aligns with family therapy sessions and therapeutic services that are currently taking place or being or need further attention due to changes within family dynamics that may impact the trajectory of the clients individual treatment.

4. Phoenix House is committed to the development of agency Case Managers assigned client caseloads and addressed the deficiency of failing to provide sufficient efforts towards assisting client with establishing important relationships with identified family members and strategically constructing opportunities to maintain meaningful relationships through coordinated documented efforts. A training for Case Managers was held 1/14/16 to discuss the importance of creating comprehensive documentation that firmly defines the status of meaningful relationships to further create opportunities for connectivity with family members throughout the treatment process.

5 Phoenix House is committed to the development of agency Case Managers assigned client caseloads and addressed the deficiency of Initial NSP Completion and Placement Date being unclear due to the dates being the same, overall concerns with not being comprehensive, Concurrent Case Plan and Case Plan Goal incongruent construction, untimely exam dates, lack of SMART goals and Life Skill training during our scheduled Quality Records and Service Utilization Committee meeting on 1/14/16. Committee members reviewed these deficiencies to better understand action steps that needed to assist Case Managers with improved construction of accurate and comprehensive NSP's. A formal training for Case Managers in regards to better utilizing the SMART format in relation to creating comprehensive NSP's was conducted on 2/16/16 as part of the LA Probation Audit review. A scheduled formal training with DPO Juarez of LA County Probation Department was held 2/25/16 to review the SMART goal format and best practices towards constructing fluid and comprehensive NSP's.

6. Phoenix House is committed to the development of agency Case Managers assigned client caseloads and addressed the deficiency of overall Quarterly NSP Completion, non-pursuit of Concurrent Case Plan as identified within Initial NSP's and Quarterly Sections being left blank during our scheduled Quality Records and Service Utilization Committee meeting on 1/14/16. Committee members reviewed these deficiencies and discussed further resources that can be obtained to better assist assigned Case Managers with the development of comprehensive Quarterly NSP's. During the meeting it was identified that two per diem case managers and other clinical team members would assist in the development of comprehensive Quarterly NSP's by engaging in specific data collection efforts to support assigned case managers. Quality Assurance personnel and Committee members identified caseloads with deficiencies and began the process of assigning specific data collection tasks to identified clinical team members to ensure this process. Progress towards data collection efforts were reviewed during the 2/16/16 Case Manager Training and continue to be evaluated.

Root Cause Analysis and Quality Improvement Plan- Various sections within Needs and Services Plan documents deemed deficient during the course of LA County Probation Audit derive from staff misinterpretation of data needed to properly notate client information, failure to exercise time management from a self-discipline standpoint, infrequent requests for clarification prior to submitting documentation, increased caseloads due to staff departures and failure to properly seek necessary information from individuals in different departments needed to construct a comprehensive Needs and Services Plans. Phoenix House has hired an outside consultant to provide an evaluation of the case manager's work load and to provide processes that support the NSP training and documentation requirements. Additionally, Phoenix House is conducting weekly case manager meetings to create an open forum towards potential barriers and solution focused discussions to improve overall processes. Monthly Quality Review, & Service Utilization reviews will be conducted monthly to have a process of quality improvement for the case management team.

IV. Educational and Workforce Readiness

Findings:

1. The "Education" section of the updated NSP for one (1) of the children was unclear on the progress made. In addition, the "Outcome Goals" section did not have an educational goal to monitor the progress made. Therefore, it was unclear if this child made any academic progress.

2. Two (2) of the children did not have appropriate documentation of the Youth Development Services (YDS) they received. 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.

Corrective Action Plan:

1. Phoenix House is committed to the development of agency Case Managers assigned client caseloads and addressed the deficiency related to the Education section within NSP being unclear in regards to individual client progress. This matter was addressed within our scheduled 1/14/16 Quality Records and Service Utilization Committee meeting. Committee members discussed the importance of Case Managers speaking directly with client's assigned Education Services staff to obtain specific information that effectively identifies client progress towards educational goals. Quality Assurance personnel facilitated a training for Case Managers 1/14/16 to discuss the importance of consulting with assigned Education Services staff for individual clients to effectively indicate and document progress or non-progress of clients in the Outcome Goals section of the NSP.

2. Phoenix House is committed to the development of agency Case Managers assigned client caseloads and addressed the deficiency of clients not having appropriate documentation of Youth Development Services being provided within the program within the scheduled Quality Records and Service Utilization Committee meeting held 1/14/16. Committee members identified that agency "Life Skills 101" classes for identified clients occurs in cycles based on established curriculum, however assigned Case Managers are unaware of the selection process and curriculum utilized to support the development of life skills for clients under our care. Committee members identified 101 training for selected clients to recognize client completion, current attendance or client recommendation towards life skills training. Quality Assurance personnel facilitated a training for Case Managers 1/14/16 to discuss the importance of consulting with assigned Education Services staff for individual clients to better understand selection and recommendation process related to Life Skills 101 training to better assist clients with independent living skills development and efforts within NSP's.

Root Cause Analysis and Quality Improvement Plan - Various sections within the Needs and Services Plan related to Education and Youth Development Services deemed deficient during the course of LA County Probation Audit derive from Phoenix House Case Managers not properly communicating with assigned Education Staff tasked with interfacing with the Los Angeles County Office of Education administrative staff to obtain information related to client grades, IEP's and client progress/regression within the school environment. Director Of Operations will assist in the endeavor of engaging in healthy collaborations between both the Education Services Department and assigned Case Managers to promote meaningful conversation to create comprehensive and congruent notations within the Education and Youth Development sections of Needs and Services Plans. Ten percent of the NSP's will be reviewed monthly to see that the Needs and Services plan contains a clear and concise ILP enrollment status and clearly identified educational goals.

Health and Medical Needs

Deficiency:

Two (2) out of the seven (7) children did not have their initial medical examinations conducted within 30 days of placement. In the first chart conflicting dates in the NSP and the file made it difficult to determine when and where the exam took place. The other child's exam was conducted 14 days late. As a result, Phoenix House was out of compliance with the section "Initial Medical Exams Conducted Timely."

Corrective Action/Acknowledgement of Deficiency:

The previous Nursing Manager failed to follow the protocol established for the previous CAP. That Nursing Manager is no longer employed by Phoenix House. Please note that there are no client ID numbers listed in the Compliance Monitoring Review. As a result we were not able to review the charts in question; however a review of the system and workflow was used to complete the CAP. Occasionally problems with insurance and/or miscommunication with the previous physician have also contributed to delayed appointments.

In response to the aforementioned findings please review the following:

- A new Nursing Manager assumed the role in August of 2015. The New Nursing Manager worked with the Medical Director to develop a tracking system where data is managed using Microsoft Access. The spreadsheet is a shared document managed by the Nursing Manager and the Medical Director. The information is now centralized.
- Initial appointments are now scheduled as part of the Admissions/Intake process and occur within 30 days of intake.

On a go-forward basis the facility will adhere to the following:

- Incoming children will receive their initial exam within 30 days of admission.
- Phoenix House will not accept verbal confirmation of an exam at the previous facility. A new exam will be scheduled unless written documentation is received and uploaded in the chart.
- Insurance will be verified within one week of Admission. Problems with insurance will not preclude Phoenix House from scheduling the initial appointment. The appointment will be scheduled to occur within the first 30 days following admission. The responsible party will be billed for the associated costs.