County of Los Angeles
DEPARTMENT OF CHILDREN AND FAMILY SERVICES

425 Shatto Place, Los Angeles, California 90020
(213) 351-5602

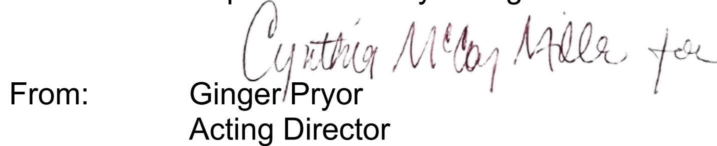
GINGER PRYOR
Acting Director

DAWNA YOKOYAMA
Interim Chief Deputy
Director

Board of Supervisors
HILDA L. SOLIS
First District
HOLLY J. MITCHELL
Second District
SHEILA KUEHL
Third District
JANICE HAHN
Fourth District
KATHRYN BARGER
Fifth District

January 26, 2022

To: Supervisor Holly J. Mitchell, Chair
Supervisor Hilda L. Solis
Supervisor Sheila Kuehl
Supervisor Janice Hahn
Supervisor Kathryn Barger



From: Ginger Pryor
Acting Director

FRED JEFFERSON MEMORIAL HOME FOR BOYS
SHORT-TERM RESIDENTIAL THERAPEUTIC PROGRAM
CONTRACT COMPLIANCE REVIEW

REVIEW OF REPORT

The Department of Children and Family Services (DCFS) Contracts Administration Division (CAD) conducted a virtual and on site Contract Compliance Review of the Fred Jefferson Memorial Home for Boys Short-Term Residential Therapeutic Program (STRTP) (the Contractor) in June 2021. The Contractor has two licensed sites located in the Second Supervisorial District. These sites provide services to the County of Los Angeles DCFS placed children, Probation foster youth, and Non-Minor Dependents.

Key Outcomes

NUMBER OF PRIORITY FINDINGS
PRIORITY 1 1
PRIORITY 2 14
PRIORITY 3 0

CAD conducted a virtual Contract Compliance Assessment review of the Contractor's compliance within the following applicable areas: General Contract Requirements; Facility and Environment; Engagement and Teamwork; Needs and Services Plans; Permanency and Transition Services; Education and Independent Living Program Services;

Health and Medical Needs; Personal Rights and Social/Emotional Well-Being; Personal Needs/Survival and Economic Well-Being; and Personnel Files.

The Contractor was in full compliance with 5 of 10 applicable areas of CAD's Contract Compliance Review: Permanency and Transition Services; Education and Independent Living Program Services; Health and Medical Needs; Personal Rights and Social/Emotional Well-Being; and Personal Needs/Survival and Economic Well-Being.

For the purpose of this review, four DCFS placed children were selected for the sample. CAD reviewed the files of the four selected children and virtually interviewed the four children to assess the level of care and services they received. An additional three discharged children files were reviewed to assess the Contractor's compliance with permanency efforts.

CAD reviewed three staff files for compliance with Title 22 Regulations and County contract requirements. CAD also conducted telephone interviews with staff. To assess the quality of care and supervision provided to the placed children and foster youth, DCFS also conducted virtual site visits of the Contractor's locations.

CAD noted findings in the areas of:

Priority 1

- Facility & Environment
  - Smoke detectors and carbon monoxide detectors were not functioning properly.

Priority 2

- General Contract Requirements
  - Special Incident Reports were not properly documented in the Needs and Services Plans.
  - Special Incident Reports were not properly cross-reported in the I-Track system.

- Engagement and Teamwork
  - Children and Family Team meetings and collaborations were not documented and maintained.

- Needs and Services Plans (NSPs)
  - NSPs were not developed timely.
  - NSPs were not comprehensive and accurate.
  - NSPs were missing the Children's Social Worker/Deputy Probation Officer signatures.
  - Child NSPs with running away history did not include individualized plan for services to address this need.

- Personnel
  - Personnel did not receive the required initial Commercially Sexually Exploited Children (CSEC), Lesbian, Gay, Bisexual, and Transgender (LGBTQ), Reproductive and Sexual Health, and Developmentally Disabled Children trainings.
  - Two personnel did not receive 40-hours of annual on-going trainings.
  - Two personnel did not receive on-going Child Abuse Identification & Reporting training.
  - Two personnel did not receive on-going CSEC, LGBTQ, Reproductive and Sexual Health, and Developmentally Disabled Children trainings.

On August 18, 2021, the Children Services Administrator teams from DCFS' CAD and the Out-of-Home Care Management Division held an exit conference with the Contractor's representatives.

The Contractor's representatives agreed with the review findings and recommendations, and were receptive to implementing systemic changes to improve the Contractor's compliance with regulatory standards.

The Contractor provided the attached approved Corrective Action Plan addressing the noted findings in this compliance report.

If you have any questions, your staff may contact me or Aldo Marin, Board Relations Manager at (213) 351-5530.

GP:KDR
LTI:ra

Attachments

c: Fesia Davenport, Chief Executive Officer
Arlene Barrera, Auditor-Controller
Dr. Adolfo Gonzales, Chief Probation Officer
Public Information Office
Audit Committee
Dr. Cecilia Jefferson-Freeman, Chief Executive Officer, Fred Jefferson Memorial Home for Boys
Kellee Coleman, Regional Manager, Community Care Licensing Division
Monique Marshall-Turner, Regional Manager, Community Care Licensing Division

LOS ANGELES COUNTY

FRED JEFFERSON MEMORIAL HOMES (STRTP)

Corrective Action Plan

2021

GENERAL CONTRACT REQUIREMENTS

5. Special Incident Reports (SIRs) are properly documented.

5.1 SIR Documentation is in the Needs and Services Plans (NSPs) [Master Contract §§19.2 & 19.6; ILS §87068.3(c)].

Facility
Site 594
Site 595
Site 594

5.2 SIRs were properly cross-reported in the I-Track System [ILS §87061(j); Master Contract, Exhibit A-VIII; SOW, Part B §10.4].

Facility
Site 594
Site 595
Site 595
Site 594

1. Explain the Cause.

5.1 The FJMH Case Managers failed to properly report the SIR's within the NSP, as a result, the monthly reporting for the SIR was not accurately reflected in the NSP's. 5.2 Facility Managers and Direct Care staff did not properly cross-report the SIR to the CCL, CSW, DPO and OHCMD. The FJMH staff and STRTP Administrator did not ensure proper checks of all Special incidents prior to the final approval of the SIR within the I-Track System.

2. Corrective Action Taken.

5.1 The Head of Service met with the newly hired FJMH Case Managers and instructed them on procedures for reporting and documenting the number of SIR's within the NSP's. • On 9/3/2021 Chief Administrative Officer and Head of Service conducted the STRTP Foster Care Service Contract Clinical training where the STRTP Statement of Work was provided and reviewed with both the Case Manager and Therapists. • On 10/13/2021 Case Managers and Therapists were trained on the NSP's. During NSP training case managers and therapists were provided detailed information regarding all Special Incident Reports guidelines and FFA contract requirements. 5.2 Beginning 10/30/2021 once a SIR is completed, it shall be saved within the I-track System and the STRTP Administrator or Facility Manager will review for proper cross reporting to CSW, CCL, DPO, OHCMD, and ensure SIR's are submitted timely.

3. Explain what the Quality Assurance (QA) Plan is to maintain Compliance.

5.1 The Head of Service will be responsible for monitoring the monthly NSP to ensure that the reporting numbers for the SIR are accurately reflected within the NSP. Case Manager will review I-Track system for all submitted SIRs for the month. On a monthly basis, the Case manager submits all NSP to the Head of Service. The Head of Service will review all NSP's for accuracy and ensure all Special Incident reports for the month are documented within the NSP. 5.2 All STRTP staff will be trained on proper cross- reporting within the I-track system. This cross-reporting includes CSW, DPO, OHCMD, and CCL. The training will be conducted on 11/5/2021 and the sign-in sheet and agenda will be maintained in Human Resources. Facility Managers will provide a bi-weekly report to the Administrator of staff of whom require additional training due to continued errors of cross-reporting. The Administrator will schedule additional training for those Direct Care staff or Managers. The Administrator will oversee the process and conduct an internal audit of all SIR's from both Direct Care Staff and Facility Manager once a month.

FACILITY AND ENVIRONMENT

8. Common quarters are well maintained.

8.6 A functioning smoke detector & carbon monoxide detector is installed in hallways of all sleeping areas [Title 22 §80020; Title 19 §754] or an indoor sprinkler system is used [Title 19, c. 5, Art. 4].

Facility
Site 594

1. Explain the Cause.

8.6 The smoke detectors weren't being check on a regular basis by the Facility staff.

2. Corrective Action Taken.

8.6 On 6/28/21, the two non-working/missing smoke detectors were immediately replaced in the hallway, sleeping area, and residents' bedrooms as stated above and verified during the walkthrough on 6/28/2021.

3. Explain what the Quality Assurance (QA) Plan is to maintain Compliance.

8.6 Smoke detectors will be closely inspected bi-weekly and documented by a Facility Managers. A bi-weekly Inspection form has been re-introduced at Facility Managers meeting on 10/14/2021, which was conducted by STRTP Administrator. If a smoke detector is found to be not working, it will be changed immediately by the Facility Manager. A quarterly check will be conducted by the STRTP administrator during the months of January, April, July, and October to ensure agency compliance.

ENGAGEMENT AND TEAMWORK

14. The child's CFT meetings & collaboration are documented and maintained.

Facility
Site 595
Site 594

1. Explain the Cause.

The agency Case Manager failed to adhere to policy of completing and placing copies of all CFT matrix notes in resident’s chart. The Case Manager also failed to Indicate in the resident’s file when youth refused to participate in scheduled CFT meetings resulting in deficiency of CFT matrix and documentation of attempted meeting and collaboration within the chart. The Case manager did not include staffing meeting notes that were held in place of CFT documenting collaboration and teamwork(staffing is held in place of missed CFT to discuss permanency plan, discuss resident goals, and interventions, reschedule CFT, etc.) when youth refuses to participate in meetings. Since December 2020 the agency has had three turnovers in the case manager role. The previous Case managers assigned to resident failed to adhere to policy of requesting and placing copies of all CFT matrix notes in resident’s chart resulting in missing CFT Matrices for August and December 2020. The resident’s services were/are being provided by an outside provider (MH Services/CFT Facilitation). The case Manager is responsible to request all CFT Matrices after meetings and place within the client’s file. The Head of Service and STRTP Administrator failed to complete adequate quality assurance of charts and were unaware that CFT matrix were missing to follow up with case manager.

2. Corrective Action Taken.

On 9/3/2021 the Chief Administrative officer and Head of Service conducted the STRTP FC Service Contract Clinical Training where the STRTP Foster Care Service Contract Statement of Work was provided and reviewed with both Case Manager and Therapists. The Case Manager and Therapist were re-trained on the requirement of CFT meetings & collaboration being documented and maintained within the resident’s file (CFT Documentation Process). The training facilitator emphasized the importance of documenting refusals within the client’s chart ie: noting within needs and service plan, documenting on CFT Matrix client’s refusal, including staffing notes) , and attaching email notification of attempts to collaborate (coordinate, schedule, or reschedule meetings) to the needs and service plans when CFT meetings are rescheduled due to staffing cancellations, client refusals or any unforeseen circumstances. On 10/12/2021 the STRTP Administrator and Head of Service were retrained on completing monthly quality Assurance of all charts to ensure that all documents are maintained within the residents’ charts to ensure that all CFT Matrix and notification of meeting cancellations or rescheduled notifications are attached to NSP and included within resident's chart.

3. Explain what the Quality Assurance (QA) Plan is to maintain Compliance.

In order to maintain compliance beginning on 9/3/2021 the Head of Service is to oversee engagement and teaming documentation process. The case manager is to submit completed CFT Matrix to the Head of Service within 48 hours of completion of CFT for review. Case Manager is to place all completed CFT documentation to resident’s file within 72 hours of completion of CFT meeting or staffing. The Case Manager is to document on CFT Matrix form any refusals to participate in CFT meetings and if a staffing was held place of cancelled CFT the Case Manager is to attach the staffing form to CFT Matrix. The Case Manager is to attach email notifications to monthly NSPs to document collaboration and teaming attempts to needs and service plans when CFTs are rescheduled due to staffing unavailability, resident refusal, or any unforeseen reason. The Case Manager is to also document in monthly NSP when youth refuses CFT meetings or the need to reschedule meetings due to provider unavailability. The STRTP Administrator is to complete monthly Quality assurance review to ensure all documents are maintained within the resident’s file (ie: NSP's, CFT meetings, and Staffing notes). The STRTP Administrator will inform both the Head of Service and Case Manager of findings (ie: missing CFT meeting notes and staffing notes). The Case Manager will have 48 hours to submit all missing documentation to head of service for review to submit to resident’s chart. The STRTP QA File Review to begin 10/31/2021. In order to maintain compliance the Head of Service is to provide an annual refresher training (every January) on the Teaming and Engaging and Documentation Process. A refresher training is also provided to the case manager or therapist observed during QA process who continuously struggle with completing and maintaining CFT meetings and collaboration.

NEEDS AND SERVICES PLANS

16. The NSPs were completed accurately and on time.

16.1 NSPs were developed timely. [SOW Part C §§19.2, 19.5, & 19.6; ILS §§87068.22(b)(2) & (e), & 87068.3(a)].

Facility
Site 595

16.2 NSPs were comprehensive & accurate.[Title 22 §84268.3(c); SOW Part C §§19.2, & 19.6; ILS §§87068.22(c) & 87068.3(a)].

Facility
Site 594
Site 594
Site 595
Site 595

16.5 The CSW/DPO signed the NSPs.[SOW, Part C §19.7; ILS §§87068.2(e), & 87070(c)(1) & (4)].

Facility
Site 594
Site 594
Site 595

1. Explain the Cause.

16. The Agency failed to implement plans of Operation requirements of completing NSP accurately and timely. Case Manager failed to complete NSP timely. STRTP Administrator and Head of Service failed to complete quality assurance of files and needs and service plans to indicate NSP had not been completed and placed within the resident chart. Head of Service failed to complete quality assurance of needs and service plans to ensure they were accurate and comprehensive resulting in multiple findings of inaccurate information, missing information, missing medical information, or information not being updated monthly, or copying and pasting of other resident's information. The Head of Service failed to complete quality assurance of needs and service plans to ensure signatures have been attained timely or attempts attached to the NSP. Case Manager failed to implement plan of operation protocol regarding signature attainment.

2. Corrective Action Taken.

On 9/3/2021 the Chief Administrative Officer and Head of Service conducted the STRTP Foster Care Service Contract Clinical training where the STRTP Foster Care Service Contract Statement of Work was provided and reviewed with both Case Manager and Therapists. During the training the process of attaining CSW signatures and escalation process was reviewed. The Head of Service will perform Quality Assurance of all needs and service plans to ensure the Case Manager is capturing all required signatures by the due date, NSP are completed timely, individualized, developed timely, and are comprehensive and accurate. On 10/13/2021 the Head of service, Therapist, and Case Manager attended further needs and service training. The 10/13/21 NSP training topics included completing needs and service plans timely, completing accurate and comprehensive needs and service plans, individualization of NSPs, updating information monthly, policy regarding attaining timely CSW signatures and escalation process. During the training the Case Manager, Therapists and Head of Service have been provided documentation on how to escalate need for signature should it not be attained during required timeline (after two attempts). Fred Jefferson has hired a second Case Manager in order to lower the caseload of Case Managers to improve compliance of timelines, comprehensive and accurate need and service plans.

3. Explain what the Quality Assurance (QA) Plan is to maintain Compliance.

Beginning 8/3/2021 In order to maintain compliance, The Case Manager will now submit all NSP's to the Head of Service electronically for review and approval before submission into youth's file. The Head of Service to audit all needs and service plan to ensure they have been completed accurately. The Head of service is to utilize NSP Audit tool to ensure all information is accurate and comprehensive. When revisions are needed the Head of Service is to return Audit tool to case manager with comments. The Case Manager is to update the NSP to reflect revisions and resubmit to the Head of Service for approval prior to due date. In order to maintain compliance the Head of Service will implement on 10/31/021 NSP Tracker spread sheet to track due dates of all NSPs. The Head of Service shall provide Case Managers and Therapist a copy of NSP tracker. The Case Manager to submit NSP prior to due date for review and approval by Head of Service. On 10/13/2021, the process was updated that All NSPs shall be provided to CSW/Probation officer within 5 days. The Head of service to oversee process of signature request. The Case Manager or Therapist will make two attempts to contact the CSW to obtain the required signatures on the NSP. The Case Manager or Therapist will attach attempts to needs and service plan, Regional Office NSP in-box or contact the PCW RBS Supervisor or Director for assistance. The Case Manager is responsible for submitting all Needs and Service Plans to the Head of Service for review and approval to ensure all NSPs are accurate and comprehensive and that all signatures have been attained. Head of Service to conduct Quality of Assurance of all NSP utilizing audit tool to ensure signatures are being attained timely or attempts made are attached to NSP. In order to maintain compliance the Head of Service will provide an annual refresher NSP training to the Case Manager and Therapist. The Annual NSP training to be held every year in January. A refresher training is also provided to the Case Manager or Therapist observed during QA process who continuously struggle with completing accurate, timely, and attaining CSW signatures and will also be provided to all newly hired Case Managers and Therapist during new hire orientation. The NSP refresher training topics to include completing needs and service plans timely, completing accurate and comprehensive needs and service plans, individualization of NSPs, updating information monthly, and policy regarding attaining timely CSW signatures and escalation process.

19. If child is CSEC or has a history of running away, the STRTP & CFT developed an individualized plan for services to address this need.

Facility

Site 595

1. Explain the Cause.

The Agency failed to follow protocol written in plan of operation and ILS Standard. The Therapist failed to identify safety need of child to create an individualized plan or specific goals to address. The Head of Service failed to implement Quality assurance resident's needs and service plan and treatment goal to ensure specific goals and services were provided to address the need of the child.

2. Corrective Action Taken.

In order to maintain compliance the Head of Service is to oversee the process of creating specific and individualize goals. The Head of Service is to review all needs and service plans and CFT Matrixes to ensure goals and services address any history of CSEC or Run-Away history. On 10/13/2021 the Head of Service, Case Manager, and Therapists attended Needs and Service Plan training. During the needs and service training requirement of creating specific individualized goals or safety plans to address the runaway behaviors were reviewed. Training also reviewed goal creation and utilizing the child and family team to a develop an individualized plan for services to address this need (CSEC or Runaway History). On 10/13/2021 the Head of Service met with Department of Mental Health Coaching and Training department to provide coaching to Case Manager, Head of Service and therapist regarding CFT process and utilizing CFT to create specific goals or individualized plan for services to address client needs. The Head of Service to participate in all coaching and training sessions. Initial coaching session to start 10/26/2021

3. Explain what the Quality Assurance (QA) Plan is to maintain Compliance.

The Head of Service to audit all needs and service plan to ensure they have been completed accurately. As of 10/13/2021 The process was updated the Case Manager will submit all NSP’s to the Head of Service electronically for review and approval before submission into youth’s file. The Head of Service is to utilize NSP Audit tool to review all goals and services to address the youth’s needs. The Head of Service to return Audit tool with comments if any revisions are needed. Case Manager to update NSP to reflect revisions and resubmit to the Head of Service for approval prior to due date. Please see Audit tool attached. In order to maintain compliance the Head of Service will provide annual NSP and refresher NSP training to the Case Manager and Therapist on developing an individualized plan for services to address needs of residents (ex: CSEC or Run away history, etc.). The Annual training to be held every year in January. A refresher training is also provided to the Case Manager or Therapist observed during QA process who continuously struggle with developing an individualized plan for services to address needs of the residents (ex: CSEC or Run away history, etc.)

PERSONNEL FILES

83.Personnel received initial training & orientation.

83.4 Personnel received CSEC training. [Title 22 §87065.1(c)(3)(V)].

Facility
Site 594

83.5 Personnel received LGBTQ training [Title 22 §84065(i)(3)(S) & (T); ILS §87065.1(c)(3)(S)].

Facility
Site 594

83.6 Personnel received 8 hours of reproductive and sexual health training [SB 89 §51; SOW, Part B, §9.3].

Facility
Site 594

83.7 Personnel received 2 hours of developmentally disabled children training.[SOW, Part B, §9.3].

Facility
Site 594

1. Explain the Cause.

83. The required training was not completed and FJMH failed to monitor, track, and maintain training compliance

2. Corrective Action Taken.

83. FJMH will conduct initial training and orientation with all new incoming personnel and ensure that all initial training are completed within the first 12 months of their hire dates. The STRTP Administrator will make sure all training sign-in, agenda, and or certificates sheets are collected and submitted to the Human Resources Department within 7 days of the training. A training schedule will be created yearly to ensure staff compliance by 11/19/2021.

3. Explain what the Quality Assurance (QA) Plan is to maintain Compliance.

83. The STRTP Administrator and assigned trainer will ensure that all new hire employees receive the New Hire Orientation training and complete the documentation (Sign-in Sheet). After each training, the Administrator will assure that the sign-in sheet and training certificates are properly filed in the Human Resources Department. A compliance check will be conducted of the employee files bi-monthly by the Human Resources Generalist to ensure agency compliance

84. Personnel received annual on-going training.

84.3 Personnel received 40 hours of on-going training. [ILS §87065.1(d)(1)].

Facility
Site 595
Site 594

84.4 Personnel received on-going Child Abuse Identification & Reporting training. [Title 22 §§84065(j)(3)(O) & (i)(3)(C); ILS §§87065.1(d)(4)(N) & (c)(3)(C)].

Facility
Site 595
Site 594

84.5 Personnel received on-going CSEC training. [Title 22 §§87065.1(d)(4)(N) & (c)(3)(V)].

Facility
Site 595
Site 594

84.6 Personnel received on-going LGBTQ training. [Title 22 §§84065(j)(3)(O) & (i)(3)(S) & (T); ILS §§87065.1(d)(4)(N) & (c)(3)(S)].

Facility
Site 595
Site 594

84.7 Personnel received on-going reproductive and sexual health training. [SB 89 §51; SOW, Part B, §9.3].

Facility
Site 595
Site 594

84.8 Personnel received 2 hours of on-going developmentally disabled children training. [SB 89 §51; SOW, Part B, §9.3].

Facility
Site 595
Site 594

1. Explain the Cause.

The initial cause was due to Covid-19 and closure of our Corporate Office. No in-person training were conducted since the beginning of the pandemic. Virtual training were offered to staff, however some staff weren't completing the training and no oversite was conducted by FJMH.

2. Corrective Action Taken.

FJMH has added mandatory training to its employee handbooks. A meeting was conducted on 10/14/2021 with all STRTP employees, and they were informed that their attendance is mandatory at all training. A training schedule has been implemented to ensure compliance by December 10, 2021

3. Explain what the Quality Assurance (QA) Plan is to maintain Compliance.

FJMH will be conducting a complete check of all personnel files, to assure complete compliance with required training. FJMH will conduct training for all staff during the month of October, November, and through December 10th, 2021. Training will include 40 Hours of On-going Training, Child Abuse Identification and reporting, CSEC, LGBTQ+, reproductive and sexual health, and developmentally disabled children. This training will be completed by December 10th, 2021 for STRTP staff.