County of Los Angeles
DEPARTMENT OF CHILDREN AND FAMILY SERVICES

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BRANDON T. NICHOLS
Director

October 24, 2023

To: Supervisor Janice Hahn, Chair
Supervisor Hilda L. Solis
Supervisor Holly J. Mitchell
Supervisor Lindsey P. Horvath
Supervisor Kathryn Barger

From: Brandon T. Nichols
Director

DAVID AND MARGARET HOME DBA
DAVID AND MARGARET YOUTH & FAMILY SERVICES
FOSTER FAMILY AGENCY
CONTRACT COMPLIANCE REVIEW

REVIEW OF REPORT

The Department of Children and Family Services (DCFS) Contracts Administration Division (CAD) conducted a virtual Contract Compliance Review of David and Margaret Home dba David & Margaret Youth and Family Services Foster Family Agency (the Contractor) in September 2022. The Contractor has one office located in the Fifth Supervisorial District. The office provides services to the County of Los Angeles DCFS and Probation placed children, children placed by other counties, and Non-Minor Dependents.

Key Outcomes

NUMBER OF PRIORITY FINDINGS
PRIORITY 1 4
PRIORITY 2 25
PRIORITY 3 1

CAD conducted a virtual Contract Compliance Assessment review of the Contractor's compliance within the following applicable areas: General Contract Requirements; Resource Family Home (RFH) Requirements; Facility and Environment; Engagement and Teamwork; Needs and Services Plans; Permanency; 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 2 of 11 applicable areas of CAD's Contract Compliance Review: Education and Independent Living Program Services; and Personnel Files.

For the purpose of this review, six DCFS placed children were selected for the sample. CAD reviewed the files of the six selected children and virtually interviewed four of the children to assess the level of care and services they received; two children (ages 0 to 2 years) were too young to be interviewed and were virtually observed to be clean and well-groomed. An additional four discharged children files were also reviewed to assess the Contractor's compliance with permanency efforts.

CAD reviewed four RFH files and four staff files for compliance with Title 22 Regulations and County contracting requirements. CAD also conducted telephonic interviews with staff and the Resource Family Parents (RFPs). To assess the quality of care and supervision provided to the placed children, CAD also conducted virtual site visits of the Contractor's location and RFHs.

CAD noted findings in the areas of:

Priority 1

- General Contract Requirements (3 findings)
    - Special Incident Reports for three children were not timely submitted and not properly cross-reported in the I-Track system.
- RFH Requirements (1 finding)
    - One RFP did not have a current water safety training on file.

Priority 2

- General Contract Requirements (1 finding)
    - The Contractor did not ensure disaster drills were conducted timely and documented in the RFP case files.
- Engagement and Teamwork (4 findings)
    - The Child and Family Team (CFT) members/participants for one child were not identified and documented in the Needs and Services Plans (NSPs) nor did the Foster Family Agency (FFA) document efforts to obtain the information.

  - The Contractor did not document efforts to collaborate and participate in the child's CFT meetings. The FFA did not have copies of the CFT meeting notes, or any documentation of efforts to obtain the CFT Meeting notes.
  - Two children NSPs were not in alignment with services as identified in the CFT notes.

- RFH Requirements (2 findings)

  - The Contractor inquiry with the Out-of-Home Care Management Division for RP files was incomplete as it was unable to be verified that a reference check was conducted prior to approval of the RP.

  - One RP did not complete Tuberculosis screening timely.

- Facility and Environment (1 finding)

  - A vehicle used to transport children was not well maintained and a maintenance log or proof of regular/annual service was not current.

- Needs and Services Plans (4 findings)

  - Four children NSPs were not timely signed by the RFP, the FFA staff, or the Children's Social Worker (CSW) or Probation Department's Deputy Probation Officer.

- Permanency (5 findings)

  - Four children discharge summaries were not submitted to the CSW timely and did not identify being discharged according to the children permanency plan.

  - After support services were not identified and linkages were not made available to ensure successful transition to permanent home-based care for one child.

- Health and Medical Needs (4 findings)

  - One child did not receive the required follow-up medical examination timely. The FFA did not provide documentation on attempts to complete the follow-up.
  - Sexual and reproductive health rights information was not provided to three children, ages 10 and older.

- Personal Rights and Social/Emotional Well-Being (2 findings)

  - Two children reported not being able to discuss their reproductive or sexual health with RFP(s) or FFA personnel.

- Personal Needs/Survival and Economic Well-Being (2 findings)

  - Lifebooks were not developed or kept for two very young children (ages 2 years and 7 months).

Priority 3

- Needs and Services Plans (1 finding)

  - Children NSPs were not completed accurately and on time.

On November 2, 2022, the Children Services Administrators teams from DCFS' CAD and the Out-of-Home Care Management Division held an exit conference with the Contractor representatives.

The Contractor 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) 371-6052.

BTN:CMM
LTI:gt

Attachments

c: Fesia Davenport, Chief Executive Officer
Oscar Valdez, Auditor-Controller
Guillermo Viera Rosa, Chief Probation Officer
Public Information Office
Audit Committee
Daniel S. Maydeck, President and Chief Executive Officer, David and Margaret Home
Kellee Coleman, Regional Manager, Community Care Licensing Division
Monique Marshall-Turner, Regional Manager, Community Care Licensing
Celeste M. Fitchett, MSW, Bureau Chief, Fiscal and Performance Audits
Celeste Fitchett, Bureau Chief, Fiscal and Performance Audits California Department of Social Services

LOS ANGELES COUNTY

DAVID & MARGARET HOME, INC. (FFA)

Corrective Action Plan

2022

GENERAL CONTRACT REQUIREMENTS

5. The FFA ensured disaster drills were conducted and documented in the RFPs case files, occurring at a minimum of every six (6) months. Title 22, Section 80023(d) ILS Section 88487.5 (c)

Facility

Site 1007

1. Explain the Cause.

The resource parent had a youth move out at the point in time when the 6 month disaster drill would be due, however, the dates overlapped by 4 days making the resource parent non-compliant and this was not corrected by the agency at the time. His home did not have a placement for one month in between. The resource parent then conducted a disaster drill with the new placement. Although the January 2022 drill was the first with the new placement in the home, the resource home was still out of compliance with the original placement as the drill was due no later than 11/13/21 and the youth moved out 11/17/21.

2. Corrective Action Taken.

Disaster drills are conducted in the presence of the agency social worker or program assistant and documented to ensure compliance.

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

A new policy and procedures are being created currently which will go into effect 12/30/22. Disaster drills will be completed at initial placement and quarterly (Jan, April, July, Oct) during in home visits and will be documented as such in both the home log and the social worker case note. Disaster drills will take place when all residents of the home are present. During quarterly inspections, the program assistant will verify and make a copy of the drill documentation for the previous quarter and the Program Director will review case notes and program assistant QA checklists for accuracy. For families who do not have placements, Program Assistant will document correspondence to encourage resource parents to continue conducting disaster drills. The agency will retrain staff on the importance and implementation of disaster drills. Quarterly resource parent home file audits and/or case note documentation will be conducted to ensure that disaster drills are taking place. Staff were trained on the upcoming policy changes as well as the importance of disaster drills and proper documentation on November 30, 2022

1. Special Incident Reports are properly documented.

1b. Properly cross-reported in the I-Track system Contract, Exhibit A-5, SOW, Part B, Section 10.4(Contract, Exhibit A-5, SOW, Part B, Section 10.4)

Facility
Site 1008
Site 1007
Site 1010

1. Explain the Cause.

Staff not properly being trained and supervisor did not verify submission . The incident reports identified were completed by a new staff and an intern who had not utilized proper training to submit the SIRS including who to cross report to and not to wait for internal written reports before creating itrack electronic reports.

2. Corrective Action Taken.

Staff being retrained on proper reporting requirements. Resource parent was new foster parent and re-trained on reporting guidelines.

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

A new policy and procedure are being created currently on proper reporting and submission of special incident reports including type of incident to report, timeframe for electronic submission, who the reports should be cross reported to, and supervisor approval of reports which will go into effect 12/30/22. Assustance was received from CCL as well as OCHMD in August, 2022 to begin creating the new policy and procedures. A tracking system for incidents has been created and was implemented 11/1/22 to ensure that proper submission and cross reporting of incidents occurs which is reviewed weekly in supervision with the Program Director. Staff were trained on the importance of proper submission of itrack reports by the Program Director on 11/30/22 and will be trained on the new policy no later than 12/30/22. Foster parents will be trained on the new reporting matrix and guidelines no later than 1/31/23 by the Program Director.

ENGAGEMENT AND TEAMWORK

20. The child's CFT team members/participants are identified and documented in the NSP OR the FFA has documented efforts to obtain the information SOW, Part C, Sections 14.0, 15.5, 19.2, 20.3

Facility
Site 1009

1. Explain the Cause.

Previously, workers had not been trained to document CFT teams, meetings, outcomes on NSPs. FFA social workers were not being invited to CFTs or were not requesting CFTs in appropriate timeframes for appropriate reasons.

2. Corrective Action Taken.

Staff were educated on the importance of CFT, the policy regarding minimum CFT timelines, the purpose behind CFT, the varied participants, requesting CFTs and ensuring documentation of CFTs or requests. In addition, staff were trained on properly documenting CFT meetings or requests in NSPs.

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

A new policy and procedures are currently being created on proper submission timeframes and content of NSPs which will go into effect by 12/30/22. All NSPs will contain a goal for, at minimum, CFTs every 6 months to ensure proper service provision, permanency and collaboration between the case members. The members of the CFT will be listed in the participant section of the goal. A tracking system was put in place in October, 2022, via excel spreadsheet that is updated monthly and reviewed weekly in supervision with the Program Director to track CFTs and alert agency social workers to inquire with the CSW as to who the team members are if not known and when the next CFT will take place. Quarterly peer review case file audits which are then reviewed by the Program Director will track if a CFT has occurred, if documentation is present or if attempts to obtain information have been documented. Agency social workers were trained on 11/30/22 on the structure, composition, goals, timeframes of NSPs and given an overview of CFT meetings and the importance of using CFT meetings in goal development.

21. The FFA documented efforts to collaborate and participate in the child's CFT meetings OR the FFA obtained copies of the CFT meeting notes SOW, Part C, Sections 14.0

Facility

Site 1009

1. Explain the Cause.

Previously, workers had not advocated for participation in CFT meetings nor had they maintained documentation of requesting CFT meetings.

2. Corrective Action Taken.

Staff were educated on the importance of CFT, the policy regarding minimum CFT timelines, the purpose behind CFT, the varied participants, requesting CFTs and ensuring documentation of CFTs or requests. In addition, staff were trained on properly documenting CFT meetings or requests for CFTs with CSW.

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

A new policy and procedures are currently being created on CFT and participation in CFT to be implemented by 12/30/22. A tracking system was put in place in October via excel spreadsheet that is updated monthly and reviewed weekly in supervision with the Program Director to track CFTs and alert agency social workers to inquire with the CSW as to who the team members are if not known and when the next CFT will take place and if the Program Director needs to escalate to the SCSW. Quarterly peer review case file audits which are then reviewed by the Program Director will track if a CFT has occurred, if documentation is present or if attempts to obtain information have been documented. The Program Director gave an overview training on CFT to staff on 11/30/22.

22. The child's NSPs are in alignment with services as identified in the CFT notes. [SOW, Part C, Sections 14.0, 19.1.2 and Master Contract, Exhibit A, Title 22, 80068.2; 80069.8(k), 88068.2; FFA ILS Chapter 8.8 Section 88289.1; SOW Part C, 14.0 (1-5), 15.1; 19.1.2; & 19.2; Foster Youth Rights Handbook pg.38]

Facility

Site 1009

1. Explain the Cause.

Previously, workers had not advocated for participation in CFT meetings nor had they maintained documentation of requesting CFT meetings.

2. Corrective Action Taken.

Staff were educated on the importance of CFT, the policy regarding minimum CFT timelines, the purpose behind CFT, the varied participants, requesting CFTs and ensuring documentation of CFTs or requests. In addition, staff were trained on properly documenting CFT meetings or requests for CFTs with CSW.

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

A new policy is currentlybeing created on proper submission timeframes and content of NSPs and will be implemented by 12/20/22. All NSPs will contain a goal for, at minimum, CFTs every 6 months to ensure proper service provision, permanency and collaboration between the case members. The members of the CFT will be listed in the participant section of the goal. A tracking system was in place in October, 2022 via excel spreadsheet that is updated monthly and reviewed weekly in supervision with the Program Director to track CFTs and alert agency social workers to inquire with the CSW as to who the team members are if not known and when the next CFT will take place. Quarterly peer review case file audits which are then reviewed by the Program Director will track if a CFT has occurred, if documentation is present or if attempts to obtain information have been documented. CFT matrix should be submitted at the time of NSP submission to ensure that services identified in the CFT notes are incorporated into the NSP. Program Director will review any CFT documentation, previous NSP and current NSP for congruency and consistency of goals, goals that are aligned with behaviors or needed services, goals that are approved by the CFT team, outcomes, linkage to services requested or needed, explanation of service delivery and collateral collaboration prior to signing. The Program Director gave an overview training on CFT to staff on 11/30/22.

RESOURCE FAMILY HOME REQUIREMENTS

8. The FFA inquired with OHCMD and other previously approving FFA's for historical information and that a reference check was conducted prior to approval of the RFP Master Contract, Exhibit A; SOW, Part C 16.3.1, 16.4.2 & 3 and SOW, Part C, Section 16.4.2

Facility

Site 1007

1. Explain the Cause.

The OCHMD form was returned blank but the OCH staff member who was assigned to review the form's name was on the bottom. Staff did not follow up to get information, instead assumed blanks meant no information.

2. Corrective Action Taken.

FFA staff reached out to OHC to attempt to reach the staff member for clarification but the previous staff member had retired. FFA staff then contacted the resource parent to sign a new ABCDF and is requesting an updated clearance.

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

A new policy and procedure is currently being created on complete and timely submission of documentation prior to resource home certification or recertification and will be implemented by 12/30/22. Prior to submission to Program Director for approval, the resource home file will be audited by the Recruiter/Trainer for complete documentation and submission of all required documents including proper signatures from LA County. Following the audit, the Program Director will review the entire file and ensure that all required documentation is present before signing the certificate. In addition, a database is being utilized that will alert to missing documentation or expired documentation. In regards to missing documentation, reports will be run quarterly in advance to identify expiring information, will be reviewed by the Program Director and Program Assistant and the program assistant will obtain prior to expiration. The Program Director retrained the recruiter/trainer on 12/6/22 and program assistant on 11/30/22 on proper approval processes and annual requirements.

10. RFPs have current training

10c. When applicable, Water Safety certificate/training [Training Matrix][Training Matrix]

Facility

Site 1007

1. Explain the Cause.

The resource parent had an expired water safety training completed by a local agency. Because the majority of water safety certificates are through the Red Cross and have no expiration or a 99 year expiration date, staff did not catch this different certificate.

2. Corrective Action Taken.

The resource parent took the Red Cross class and provided the certificate.

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

A new policy and procedure are currenty being created on complete and timely submission and completion of training hours and will be implemented by 12/30/22. Resource home files will be peer review audited quarterly and reviewed by the Program Director for compliance including review of the database for total and complete documentation of training hours. In addition, a database is being utilized that will alert to missing documentation or expired documentation. In regard to missing documentation of training hours, reports will be run quarterly in advance to identify expiring information or deficit in training hours, will be reviewed by the Program Director and Program Assistant and the program assistant will obtain prior to expiration or annual date. The agency retrained the recruiter/trainer on 12/6/22 and program assistant on 11/20/22 on proper approval processes and annual requirements.

12. Resource Family Homes received tuberculosis screenings for all adults in the home prior to approval

Facility

Site 1009

1. Explain the Cause.

It is unclear as to why the TB took place after the certification date. Although the FFA does require repeat TB at recertification, and the foster parent had been initially certified many years before, no other documentation was found.

2. Corrective Action Taken.

The foster parent has a current TB on file. Staff are being retrained on pre-certification requirements.

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

A new policy and procedure are curently being created on complete and timely submission of documentation prior to resource home certification or recertification and will be implemented by 12/30/22. Prior to submission to Program Director for approval, the resource home file will be audited by the Recruiter/Trainer for complete documentation and submission of all required documents including proper signatures from LA County. Following the audit, the Program Director will review the entire file and ensure that all required documentation is present before signing the certificate. In addition, a database is being utilized that will alert to missing documentation or expired documentation. In regard to missing documentation, reports will be run quarterly in advance to identify expiring information, will be reviewed by the Program Director and Program Assistant and the program assistant will obtain prior to expiration. The Program Director retrained the recruiter/trainer on 12/6/22 and program assistant on 11/30/22 on proper approval processes and annual requirements.

FACILITY AND ENVIRONMENT

13. Vehicles used to transport children were well maintained and in good repair

13c. Maintenance Log or Proof of regular/annual service and maintenance (Title 22 80074(c) & 87074(d))(Title 22 80074(c) & 87074(d))

Facility

Site 1009

1. Explain the Cause.

The agency had not previously been requesting nor tracking vehicle maintenance logs regularly.

2. Corrective Action Taken.

All staff are being retrained and resource parents are being notified about the annual maintenance log requirement.

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

A new policy and procedure are currently being created on complete and timely submission and completion of required file contents including annual service and maintenance and will go into effect by 12/30/22. Resource home files will be peer review audited quarterly and reviewed by the Program Director for compliance including review of the database for total and complete documentation of file contents. In addition, a database is being utilized that will alert to missing documentation or expired documentation. In regard to missing documentation, reports will be run quarterly in advance to identify expiring information, will be reviewed by the Program Director and Program Assistants and the program assistant will obtain prior to expiration or annual date. The Program Director retrained the recruiter/trainer on and program assistant on proper approval processes and annual requirements and all staff on the annual maintenance requirement on 11/30/22. Foster parents will be notified of the new requirement no later than 1/30/23.

NEEDS AND SERVICES PLANS

23. The NSPs were completed accurately and on time [ILS, §§88268.2(c) & 88278.1(a); Master Contract, Exhibit A, SOW, Part C, §§15.0 & 16.8.]

23a. Developed timely

Facility
Site 1009

23b. Are comprehensive and accurate

Facility
Site 1007
Site 1007
Site 1009

23d. Signed by children when age or developmentally appropriate

Facility
Site 1007
Site 1007
Site 1009

23e. Signed by RFPs (and parents if applicable)

Facility
Site 1007
Site 1010
Site 1010
Site 1007
Site 1009

23f. Signed by FFA staff

Facility
Site 1010
Site 1010

23g. Signed by CSW/DPO (or documented efforts to obtain signature))

Facility
Site 1008
Site 1007
Site 1010
Site 1010
Site 1007
Site 1009

1. Explain the Cause.

Staff were not calculating the correct due dates and were not compliant in insuring NSP were submitted and signatures obtained timely. Supervisor was not tracking due dates.

2. Corrective Action Taken.

FFA staff now use the provided calculation spreadsheet, create calendar reminders and have entered NSP due dates onto an excel spreadsheet that is reviewed at each weekly supervision. Adobe is utilized to request signatures from CSWs and sends and tracks reminders which will be documented with the NSP in the file.

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

A new policy and procedure are currently being developed for the proper submission of timely and complete NSPs including content and timeframes for submission for signatures and will go into effect no later than 12/30/22. A new database is being utilized as well as a tracking excel spreadsheet effective in October that is updated monthly and reviewed weekly in supervision with the Program Director that will alert to upcoming NSPs. Prior to approval of any NSP, the agency social worker should submit the CFT matrix, the prior NSP and the current draft to ensure that all goals are appropriate based on youth need, behaviors, team discussions, CFT goals, age appropriate goals, have appropriate timelines, are consistent with CFT goals, prior goals are carried over and timelines are consistent and appropriate for the services or goals provided. NSP drafts are to be submitted two weeks in advance to the Program Director to allow for signatures at the next home visit and prior to the due date of the NSP. PMIS will facilitate CSW signatures but in the event that PMIS is not functioning, Adobe will be utilized for signatures, effective November 1, 2022, as the program automatically sends reminders and provides reports of attempts to obtain signatures. Quarterly peer review file audits which will be reviewed by the Program Director will check for timely submission and appropriate signatures. The Program Director retrained all case carrying social workers on proper completion and submission of NSPs on 11/20/22.

PERMANENCY AND TRANSITION SERVICES

34. The child's discharge summary (submitted to the CSW 30 Days from the date the child's placement was terminated) identified being discharged according to the child's permanency plan

Facility
Site 1007
Site 1009
Site 1010
Site 1008

1. Explain the Cause.

Although discharge NSPs were provided to CSWs, the agency was not in the habit of sending copies of the discharge summary.

2. Corrective Action Taken.

Discharge summaries are now being sent at the same time as discharge NSPs and are being tracked through Adobe.

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

The agency did not previously have a policy in place to submit the discharge policy to the CSW, only the discharge NSP. A new policy is currently being created to ensure the discharge summary is submitted to the CSW. Effective November 1, 2022, agency staff were notified to send all discharge summaries along with discharge NSPs to CSW. This is being tracked through Adobe. The discharge summary will be submitted to the CSW and proof of submission will be placed in the child’s file with the discharge summary. The Program Director retrained all case carrying social workers on 11/30/22 on proper completion and submission of required discharge process and documentation.

35. After support services were identified and linkages are made available to ensure successful transition to permanent home based care [SOW, Part C, Section 15.2, 15.5, 18.1, 18.13 AND [ILS, §88268.2(c); Master Contract, Exhibit A, SOW, Part C, §§15.2, 15.4 & 18.1.]

Facility

Site 1007

1. Explain the Cause.

FFA staff were either not identifying or were simply naming services that would facilitate successful transition rather than working with the CSW to ensure linkage during transition from one home or agency to another.

2. Corrective Action Taken.

FFA staff will now document services already being provided as well as services needed in discharge summaries. Prior to discharge, when possible, attempts will be made to link youth to necessary services for their next placement.

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

A new policy and procedure are being currently being created on linkage to services following discharge. The new policy and procedures will be implemented no later than 12/30/22. Discharge summaries and NSPs will not only identify the services but will describe in detail the attempts or successful linkage to needed services. This will be reviewed by the Director prior to approval of the summary and NSP. Closed files will be audited prior to archival and within 30 days of discharge. The Program Director retrained all case carrying social workers on proper completion and submission of required discharge process and documentation on 11/30/22.

HEALTH AND MEDICAL NEEDS

43. Required follow-up medical examinations were conducted on time (Contract, Section 19.0, SOW Part C, Sections 15.3.9)

Facility

Site 1009

1. Explain the Cause.

Social worker forgot to follow up on the appointment.

2. Corrective Action Taken.

The agency social worker is following up to ensure the youth attends the appropriate referral doctors. In addition, all medical visits are being reviewed and tracked via excel spreadsheet to be reviewed weekly in supervision

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

A new policy and procedure are currently being created on medical appointment documentation and necessary follow up and will be implemented by 12/30/22. Any medical appointments that require follow up will be reviewed by the Director on the appropriate document submitted by the ASW and will be tracked on the ASW monthly spreadsheet that was implemented in October 2022 to ensure next steps are followed. This will be reviewed weekly in supervision as well as at weekly home visits to ensure the follow up appointment and appropriate documentation take place and are documented. In addition, quarterly peer file audits which will be reviewed by the Program Director will track and ensure that medical documentation is complete. The Program Director retrained case carrying social workers on medical appointment guidelines, documentation and follow up on 11/30/22.

45. The FFA has provided sexual and reproductive health rights information, age 10 or older (SOW Part C, Section 15.3.10, Senate Bill 89)

Facility
Site 1007
Site 1007
Site 1009

1. Explain the Cause.

The agency was not compliant with this requirement and did not have a regular practice of providing this information other than the reproductive rights section of the clients rights form.

2. Corrective Action Taken.

Agency social workers were immediately trained on providing sexual reproductive rights and all youth ages 10 and up on caseloads were identified. Social workers provided the sexual reproductive rights pamphlets to each youth and discussed their rights and documented the discussion in case notes.

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

A new policy and procedure are currently being created regarding sexual reproductive health and rights and will go into effect prior to 1/30/23. The agency currently utilizes personal rights that includes information about sexual reproductive health and rights but this information is not expounded upon every six months when personal rights are reviewed. The agency will began including sexual reproductive health and rights in the intake information signed at placement for children age 10 and up effective 11/1/22. In addition, the monthly tracking spreadsheet which was implemented in October 2022 and utilized by ASW will include the dates that information is discussed with minors age 10 and up, a section is being added to the home visit documentation form, which is reviewed by the Program Director, for documenting the information and quarterly peer file audits, which will be reviewed by the Program Director, will confirm that the information has been disseminated and discussed per policy. The Program Director trained all case carrying social workers on 11/30/22 on providing the information and documenting the provision in appropriately.

PERSONAL RIGHTS AND SOCIAL/EMOTIONAL WELL-BEING

60. Children reported being able to discuss their reproductive or sexual health with RFP(s) or FFA personnel, if they desire to (ILS Section 88487.15(e))

Facility
Site 1007
Site 1007

1. Explain the Cause.

The agency was not compliant with this requirement and did not have a regular practice of providing this information other than the reproductive rights section of the clients rights form.

2. Corrective Action Taken.

Agency social workers were immediately trained on providing sexual reproductive rights and all youth ages 10 and up on caseloads were identified. Social workers provided the sexual reproductive rights pamphlets to each youth and discussed their rights and documented the discussion in case notes.

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

A new policy and procedure are being created regarding sexual reproductive health and rights. The agency currently utilizes personal rights that includes information about sexual reproductive health and rights but this information is not expounded upon every six months when personal rights are reviewed. The agency will begin including sexual reproductive health and rights in the intake information signed at placement for children age 10 and up as of 11/1/22. In addition, the monthly tracking spreadsheet utilized by ASW, and reviewed in weekly supervision by the Program Director was implemented 10/2022 and will include the dates that information is discussed with minors age 10 and up, a section is being added to the home visit documentation form for documenting the information and quarterly file audits will confirm that the information has been disseminated and discussed per policy. The Program Director trained all case carrying social workers on providing the information and documenting the provision in appropriately on 11/30/22.

PERSONAL NEEDS/SURVAVAL AND ECONOMIC WELL-BEING

63. The FFA ensures that children are encouraged and supported by the RFPs in keeping a life-book (SOW, Part C, Section 17.12) and [Master Contract, Exhibit A, SOW, Part C, §17.12]

Facility
Site 1010
Site 1010

1. Explain the Cause.

Although the resource parent had many pictures, they were not documented in the child's life book.

2. Corrective Action Taken.

The agency social workers have been educated on lifebook requirements and are educating resource parents as well as checking lifebooks at home visits to ensure compliance.

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

A new policy and procedure are currently being created regarding the intention and use of lifebooks and will go into effect 1/30/22. The agency will add a provision to check for life books as part of the quarterly Program Assistant QA of the resource home as well as adding documentation requirement for life book in the home visit documentation form. Quarterly file peer audits, which will be reviewed by the Program Director, will ensure proper documentation by the ASW that the life book was addressed, is being completed, is documented in the NSP. The Program Director retrained all staff on the importance of lifebooks and how to assist RP in the creation and maintenance of lifebooks on 11/30/22. ASW will educate the resource parents on the importance of life books no later than 1/30/23.