



County of Los Angeles DEPARTMENT OF CHILDREN AND FAMILY SERVICES

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September 29, 2025

To: Supervisor Kathryn Barger, Chair
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From:  for
Brandon T. Nichols
Director

ABOUNDING RIVERS SHORT-TERM RESIDENTIAL THERAPEUTIC PROGRAM CONTRACT COMPLIANCE REVIEW

REVIEW OF REPORT

The Department of Children and Family Services (DCFS) Contract Compliance Division (CCD) conducted a Contract Compliance Review of Abounding Rivers Services Short-Term Residential Therapeutic Program (the Contractor) in June 2025. This new Contractor has one office located in the Second Supervisorial District. The site provides services to the County of Los Angeles DCFS placed children, youth and Non-Minor Dependents (NMDs), Probation foster youth, and NMDs.

Key Outcomes

NUMBER OF PRIORITY FINDINGS
PRIORITY 1 6
PRIORITY 2 12
PRIORITY 3 1

"To Enrich Lives Through Effective and Caring Service"

The CCD conducted a 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.

This new Contractor was in full compliance with 3 of 10 applicable areas of CCD's Contract Compliance Review: Engagement and Teamwork; Permanency and Transition Services; Education and Independent Living Program Services.

For the purpose of this review, one DCFS placed child was selected for the sample. The CCD reviewed the file of the one child and interviewed the child in person to assess the level of care and services they received. An additional two discharged children files were also reviewed to assess the Contractor's compliance with permanency efforts.

The CCD reviewed four staff files for compliance with Title 22 Regulations and County contracting requirements. CCD also conducted interviews with staff to assess the quality of care and supervision provided to the placed children and foster youth, DCFS also conducted a site visit.

CCD noted findings in the areas of:

Priority 1

- Facility and Environment (2 Findings)
 - Security locks used on windows are not equipped with operable, safety release devices.
 - Disinfectants, cleaning solutions, poisons, and other dangerous items were not secured and were accessible to children.
- Personnel Files (4 Findings)
 - Four staff did not have current water safety certifications on file.

Priority 2

- General Contract Requirements (1 Finding)
 - Special Incident Reports for one child were not properly cross-reported in the iTrack system.

- Needs and Services Plans (NSPs) (1 Finding)
 - The NSP for one child was not completed accurately.
- Health and Medical Needs (1 Finding)
 - The required follow-up medical examination for one child was not conducted timely.
- Personal Rights and Social/Emotional Well-Being (1 Finding)
 - One child reported not being informed about their right to have contraceptives and a container to lock them in.
- Personnel Files (8 Findings)
 - Four staff did not complete their medical and/or Tuberculosis clearances timely.
 - Four staff did not complete their initial emergency intervention training timely.

Priority 3

Personal Needs/Survival and Economic Well-Being (1 Finding)

- One child reported not being encouraged and supported in keeping a life-book.

On July 24, 2025, the Children Services Administrator teams from the DCFS' CCD 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.

Each Supervisor
September 29, 2025
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If you have any questions, your staff may contact me or Aldo Marin, Board Relations Manager, at (213) 371-6052.

BTN:LM:RT
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Attachments

c: Fesia Davenport, Chief Executive Officer
Oscar Valdez, Auditor-Controller
Guillermo Viera Rosa, Chief Probation Officer
Public Information Office
Audit Committee
Porche Randall, Chief Executive Officer, Abounding Rivers
Fazeela Shaikh, Chief Financial Officer, Abounding Rivers
Kellee Coleman, Assist Program Administrator, LA Region CCLD
Bernice Karnsrithong, Regional Manager, Community Care Licensing Division
Monique Marshall-Turner, Regional Manager, Community Care Licensing Division
Celeste M. Fitchett, MSW, Chief Fiscal and Performance Audits Bureau

LOS ANGELES COUNTY
ABOUNDING RIVERS (STRTP)
Corrective Action Plan
2025

GENERAL CONTRACT REQUIREMENTS

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

2.2 SIRs are properly cross-reported in the I-Track System [ILS, §87061(i); Master Contract, Exhibit A-V; Master Contract, Exhibit A, SOW, Part B, §10.4][ILS, §87061(i); Master Contract, Exhibit A-V; Master Contract, Exhibit A, SOW, Part B, §10.4]

Facility

Site 1650

1. Explain the Cause.

The system was down on 04/11/2025 when the incident occurred, so staff submitted a written report as an interim measure. However, the iTrack report was not cross-reported to CCL and CSW as required. The delay in entering the SIR into iTrack on 04/15/2025 occurred because staff incorrectly believed that once the written report was completed, the requirement had been met. This reflected a misunderstanding of the protocol outlined in Exhibit A-5 regarding the requirement to both submit in i-Track within 24 hours and cross-report to all required parties.

2. Corrective Action Taken.

Immediate Review: Administrator reviewed both incidents with responsible staff after contract review. Corrective Action: As of 09/15/2025, all staff will undergo mandatory retraining on: • 24-hour SIR submission policy. • Cross-reporting requirements to DCFS, CCL, and CSW. A sign-in sheet will be maintained for training records. Monitoring: Facility Administrator will approve all SIRs within 24 hours of entry to ensure proper reporting and cross-notification. Weekly internal audits will be conducted for 90 days (through 11/30/2025), then monthly thereafter. Audit results will be reviewed during MMM and included in CQI reports. Timeframe for Corrective Action: 09/30/2025

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

2. Facility Administrator will conduct weekly audits of SIR entries in i-Track to confirm timeliness and accuracy. 3. Audit results will be reviewed monthly in MMM (Monday Morning Meetings) and incorporated into CQI (Continuous Quality Improvement) reports. Responsible Person(s): Case Manager, Facility Administrator

FACILITY AND ENVIRONMENT

8. The exterior and the grounds are safe and well maintained.

8.2 Security bars used on windows are equipped with operable, safety release devices [Title 22, §80020(a); H&S Code, §1531.4][Title 22, §80020(a); H&S Code, §1531.4]

Facility

Site 1650

1. Explain the Cause.

Abounding Rivers Administrator placed bolted locks on windows to restrict how far the windows could open (5 inches) in an effort to prevent youth from kicking out window screens and exiting through the windows during runaways, or to prevent the unauthorized entrance of others. However, we neglected to consider the emergency egress and fire safety requirements.

2. Corrective Action Taken.

On 06/13/2025, during the DCFS site inspection, the Facility Administrator and Facility Manager immediately removed the bolted locks from the windows in children’s bedrooms 1 and 3. Follow-Up: On 06/14/2025, the Facility Manager conducted a full inspection of all windows in the facility to confirm no other bolted locks were present.

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

Monthly Checks: Facility Manager will conduct monthly safety inspections of all bedrooms using a standardized checklist that includes window hardware. Oversight: The Facility Administrator will review monthly inspection checklists for accuracy and completeness. CQI Review: Quarterly, the Administrator will report inspection results in MMM (Monday Morning Meetings) and document in CQI (Continuous Quality Improvement) reports. Accountability: Any noncompliance observed will be immediately corrected and documented, with staff retraining as needed.

9. Common areas are safe and well maintained.

9.11 Disinfectants, cleaning solutions, poisons, and other dangerous items are not accessible to children [ILS, §87087(f) & (g); Title 22, §§80087(g) & 84067][ILS, §87087(f) & (g); Title 22, §§80087(g) & 84067]

Facility

Site 1650

1. Explain the Cause.

The solution had been placed under the sink by housekeeping staff for convenience after routine cleaning and was not relocated to the locked storage cabinet as required by policy. This oversight indicated a lack of training and follow-up regarding safe storage practices.

2. Corrective Action Taken.

On 06/14/2025, Facility Manager and Direct Care Staff received refresher training on Title 22 requirements for storage of cleaning materials and the facility’s Chemical Safety Policy. Updated Daily Tasks requires the Facility Manager or Direct Care Staff to verify secure storage of all cleaning solutions at the end of each shift.

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

2. Facility Manager will use a weekly grounds safety checklist to identify and correct hazards. Report will be turned into FA weekly.

NEEDS AND SERVICES PLANS

17. The NSPs are completed accurately and on time.

17.2 NSPs are comprehensive and accurate (case plans, concurrent plans, TILPs, SMART goals) [Master Contract, Exhibit A, SOW, Part C, §§19.2, 19.6, & 19.8; ILS, §§87068.2(b) & (c), 87068.22(b) & (c), & 87068.3(a)] [Master Contract, Exhibit A, SOW, Part C, §§19.2, 19.6, & 19.8; ILS, §§87068.2(b) & (c), 87068.22(b) & (c), & 87068.3(a)]

Facility

Site 1650

1. Explain the Cause.

This occurred because the Head of Service (HOS) made a typographical error when completing the Behavioral/Mental Health (Core Services Specialty Mental Health) section of the NSP.

2. Corrective Action Taken.

On 09/05/2025, the Facility Administrator and Head of Service reviewed the error and provided targeted retraining to the HOS on ensuring accuracy of medication documentation in the NSP. The HOS must verify PMA information in the Behavioral/Mental Health section against the JV223 form and medical file before finalizing the NSP. The Facility Administrator must approve and sign off on the NSP only after confirming accuracy of PMA dates and other treatment details.

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

Verification: The HOS will complete the Behavioral/Mental Health section of every NSP and verify PMA information directly against the JV223. Approval: The Facility Administrator will review and approve each NSP prior to submission, confirming PMA accuracy as part of the approval process. Ongoing QA: Existing QA processes already in place (monthly file audits, MMM reviews, and quarterly CQI audits) will be used to monitor NSP accuracy. PMA accuracy will be specifically tracked as a standing item.

HEALTH AND MEDICAL NEEDS

30. Required follow-up medical examinations are conducted timely [Title 22, §80075(a); Master Contract, Exhibit A, SOW, §15.4.1.2.1; Exhibit A-IX].

Facility

Site 1650

1. Explain the Cause.

Due to being a new facility we didn't have our Staff double checking for follow up dates and proper coordination. The follow-up appointment was scheduled, but documentation was not obtained from the staff at the time of service. This was due to a lack of a centralized system to track follow-up appointments and ensure documentation is collected and filed.

2. Corrective Action Taken.

1. Case Manager established a log to track medical appointments within 30 days of intake. 2. Case Manager confirms appointment scheduling within 48 hours of placement. 3. Weekly review of the log by Administrator to verify compliance.

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

Next Steps/Monitoring: Monthly file audits to verify timeliness; results discussed in MMM and included in CQI reporting. Responsible Person(s): Case Manager and Facility Administrator

PERSONAL RIGHTS AND SOCIAL/EMOTIONAL WELL-BEING

52. Children were informed about their right to have contraceptives and a container to lock them in [Master Contract, Exhibit A, SOW, Part C, §15.4.4.2.1; ILS, §§87075(b)(1)(A), & 87072(c)(16)].

Facility

Site 1650

1. Explain the Cause.

Our facility did not have a clear procedure on 6/13/2025 during walk through for communicating the existence and specific purpose of contraceptive lockboxes. Staff assumed residents understood their use , but this was not explicitly explained, leading to confusion.

2. Corrective Action Taken.

On 07/01/2025, Facility Manager reviewed contraceptive rights and lockbox use with all residents during the house meeting. Intake orientation packets were updated on 07/15/2025 to explicitly include contraceptive rights and lockbox acknowledgement. Resident Agreements were revised to include a signature page confirming receipt of a contraceptive lockbox. 1. Case Manager will provide youth with contraceptive lockbox upon intake. 2. Contraceptive lockbox acknowledgement will be added to resident agreement during intake. 3. Facility Administrator will review all Intake documents for quality control

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

Responsible Person(s): Case Manager, Administrator Next Steps/Monitoring: Intake Package to be reviewed by FA; compliance reviewed in MMM and CQJ audits.

PERSONAL NEEDS/SURVIVAL AND ECONOMIC WELL-BEING

57. Children report they are encouraged and supported by the provider in keeping a life-book [Master Contract, Exhibit A, SOW, Part C, §17.6.3].

Facility

Site 1650

1. Explain the Cause.

The Life-books were not distributed to the youth due to lack of coordination from FA.

2. Corrective Action Taken.

1. As of 07/01/2025, lifebooks have been issued to all residents. 2. The first week of each month is designated for structured lifebook activities, with staff assisting residents to document experiences, achievements, and milestones. 3. Facility Manager will review lifebooks during monthly file audits.

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

Next Steps/Monitoring: Lifebook updates are logged in Brightwheel, the facility's electronic data management system. Brightwheel provides time-stamped entries, staff accountability tracking, and the ability to upload photos or activity notes for lifebook sessions. Updates will also be verified during quarterly CQJ audits to ensure consistent completion.

PERSONNEL FILES

74. Personnel received all required medical clearances.

74.1 Personnel files include medical clearances within one (1) year prior to hire date or within seven (7) days after hire date [Title 22, §§80065(g)(1) & (2), & 80066(a)(10)] [Title 22, §§80065(g)(1) & (2), & 80066(a)(10)]

Facility

Site 1650

Site 1650

Site 1650

74.2 Personnel files include Tuberculosis clearances within one (1) year prior to hire date or within seven (7) days after hire date [Title 22, §§80065(g)(1) & (2), & 80066(a)(11)] [Title 22, §§80065(g)(1) & (2), & 80066(a)(11)]

Facility

Site 1650

Site 1650

1. Explain the Cause.

As a new facility, Abounding Rivers did not have fully developed systems for managing personnel records, which led to incomplete tracking of medical clearances and required documents. This was an oversight in internal file management and quality assurance procedures.

2. Corrective Action Taken.

1. All Staff must have required personnel documents prior to being scheduled to work. 2. HR completed a full audit of all personnel files by 8/05/2025.

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

Next Steps/Monitoring: Quarterly HR audits; status reviewed in MMM and included in CQI reporting. Responsible Person(s): HR, Facility Administrator

76. Personnel received initial training and orientation.

76.1 Personnel files include initial emergency intervention training (e.g. Pro-ACT) [ILS, §§87095.65(a)(1) & (d), 87095.66(b); Title 22, §84165(f)(2)(A)] [ILS, §§87095.65(a)(1) & (d), 87095.66(b); Title 22, §84165(f)(2)(A)]

Facility

Site 1650

Site 1650

Site 1650

Site 1650

1. Explain the Cause.

Due to the slow on-boarding rule and lack of funds this was done later than we anticipated.

2. Corrective Action Taken.

1. Missing clearances and training certifications were obtained and filed as of 08/05/2025. 2. All new staff must complete emergency intervention training within 14 days of hire date.

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

Monthly internal audits will be conducted to ensure continued compliance. Timeframe for Corrective Action: 08/30/2025 Next Steps/Monitoring: Quarterly HR audits; status reviewed in MMM and included in CQI reporting.

77. Personnel received annual on-going training.

77.9 If site has a pool or other body of water, there is at least one personnel member with current water safety certification on file [ILS, §87087.2(a)(5)(A); Title 22, §80065(e)(2)] [ILS, §87087.2(a)(5)(A); Title 22, §80065(e)(2)]

Facility

Site 1650

Site 1650

Site 1650

Site 1650

1. Explain the Cause.

Water safety training was not required at the time of hire because the facility pool was not yet ready for use. However, this was out of compliance with Title 22 and DCFS requirements.

2. Corrective Action Taken.

Immediate Correction: All existing staff were required to complete water safety training by 08/30/2025. Correction Completed: As of 09/01/2025, all staff have completed water safety training, and verification is on file. Policy Change: Water safety training is now a required part of the onboarding training package for all new hires. No staff will be allowed to begin shifts until water safety certification is documented.

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

Facility Administrator will verify water safety certification as part of the Personnel File Checklist for each new hire. Facility Administrator will conduct quarterly file audits to confirm certifications remain current. Training compliance will be reviewed in MMM and CQJ audits.