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April 30, 2026

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for

From: Brandon T. Nichols
Director

FIRST PLACE FOR YOUTH TRANSITIONAL HOUSING PLACEMENT PROGRAM FOR NON-MINOR DEPENDENTS CONTRACT COMPLIANCE REVIEW

REVIEW OF REPORT

The Department of Children and Family Services (DCFS) Contract Compliance Division (CCD) conducted a virtual Contract Compliance Review of First Place for Youth Transitional Housing Placement Program for Non-Minor Dependents (THPP-NMD) in October 2025. The Contractor has one licensed site located in the Second Supervisorial District. The site provides services to the County of Los Angeles DCFS and Probation NMDs between the ages of 18-21 and their children. The Contractor has five additional service sites located in Contra Costa County, San Francisco County, Santa Clara County, Solano County, and Jackson, Mississippi, that provide services to NMDs in their designated counties.

Key Outcomes

NUMBER OF PRIORITY FINDINGS
PRIORITY 1 9
PRIORITY 2 16
PRIORITY 3 2

The CCD conducted a virtual Contract Compliance review of the Contractor's compliance within the following applicable areas: Licensure and Certificate of Compliance; Personnel/Staffing/Training; Contractor/Agency Reports; THPP-NMD Participant Record Folder/Case File; THPP-NMD Participant Training; Education and Employment; Medical and Dental; and Program Exit/Aftercare Follow Up and Tracking.

The Contractor was in full compliance with 0 of 8 applicable areas of the CCD's Contract Compliance Review.

For the purpose of this review, 15 DCFS NMDS were selected for the sample. The CCD reviewed the records and files of the 15 selected NMDs to assess the level of care and services they received. An additional five discharged NMDs files were reviewed to assess the Contractor's compliance with permanency efforts. The CCD reviewed five staff files for compliance with Title 22 Regulations and County contract requirements.

The CCD noted findings in the following areas:

Priority 1

- Licensure and Certificate of Compliance (1 Finding)

    - Special Incident Reports were not completed timely in the iTrack System.

- Personnel/Staff/Training (2 Findings)

    - One staff did not complete the Involving Law Enforcement training timely.
    - Two staff failed to submit documentation of the 20 hours of annual training.

- THPP-NMD Participant Record Folder/Case File (5 Findings)

    - Two Transitional Independent Living Plans (TILPs) were updated late. Four TILPs were missing.
    - 14 participants were missing documentation of daily contact with the Case Manager.
    - Written authorization from the Children's Social Worker/Deputy Probation Officer (CSW/DPO) was not obtained prior to reducing daily contact for 14 participants.
    - Nine participants had missing documentation of weekly face-to-face contact by the Case Manager.
    - Nine participants had missing documentation of 60 minutes of visit time monthly by the Case Manager.

- THPP-NMD Participant Training (1 Finding)

    - The agency failed to provide appropriate encouragement to seven participants to attend a minimum of 240 minutes of Life Skills training monthly.

Priority 2

- Contractor/Agency Reports (2 Findings)

  - Contractor submitted four Agency Monthly Reports (A-27) late and did not maintain documentation for one month.
  - Contractor submitted one Monthly Census Report (A-32) late and did not maintain documentation for one month.

- THPP-NMD Participant Record Folder/Case File (7 Findings)

  - One Initial Needs and Services Plan (NSP) was not created timely.
  - Two Updated NSPs were missing. One Updated NSP was not created timely.
  - Two missing NSPs, hence CCD was unable to verify participant signed timely.
  - Two missing NSPs, hence CCD was unable to verify Contractor signed timely.
  - Two missing NSPs, hence CCD was unable to verify CSW/DPO signed timely.
  - One Initial Progress Report (A-20) was missing. One Initial Progress Report was not created timely.
  - Two Quarterly Reports (A-20) were missing. One Quarterly Report was missing documentation as to when it was submitted to the Contract Program Manager (CPM).

- THPP-NMD Participant Training (1 Finding)

  - Contractor did not have a discussion with the NMD participant and CSW/DPO prior to reducing the minimum minutes of training to no less than 120 minutes a month and failed to maintain documentation of the discussion for seven participants.

- Education and Employment (1 Finding)

  - Contractor did not assist two unemployed participants with registering at the local America's Job Center of California; Caljobs.gov or any department sponsored employment initiatives or programs within seven business days into the program, or within seven days of unemployment and failed to maintain documentation in the file.

- Medical and Dental (2 Findings)

  - Contractor did not encourage five participants to obtain annual medical exams and all necessary medical care and related services.
  - Contractor did not encourage five participants to obtain annual dental exams and all necessary dental care and related services.

- Program Exit/Aftercare Follow-Up and Tracking (3 Findings)

  - Contractor did not provide 30-day follow-up services timely and did not document their attempts to contact four NMDs.
  - Contractor did not provide 90-day follow-up services timely and did not document their attempts to contact three NMDs.
  - Contractor failed to complete the Aftercare Contact Form (A-36) timely and did not document when it was provided to the CPM.

Priority 3

- THPP-NMD Participant Record Folder/Case File (2 Findings)

  - Contractor did not complete one quarterly Participant Unit/Furniture Inventory (A-9).
  - Contractor did not complete one quarterly Participant Clothing Inventory (A-11).

On December 4, 2025, DCFS' CCD Children Services Administrator team and Supportive Housing Division THPP-NMD County Program Manager held an exit conference with the Contractor's representative.

The Contractor's representative agreed with the review findings and recommendations and was 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 deficiencies in this compliance report.

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

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Attachments

c: Joe Nicchitta, Acting Chief Executive Officer
Oscar Valdez, Auditor-Controller
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Thomas Lee, Chief Executive Officer, First Place for Youth
Kellee Coleman, Assist. Program Admin. LA Region, Community Care Licensing
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Contract Compliance Division
510 S. Vermont Avenue 14th Floor
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January 5, 2026

Purpose

This plan responds to the THPP-NMD compliance findings listed below and outlines corrective and preventive actions, owners, timelines, and measurable outcomes.

Overall Objectives

- Achieve one hundred percent on time submission for all required reports, assessments, and participant documents.
- Achieve one hundred percent completion and documentation of staff screenings and trainings.
- Ensure complete and current participant records, including TILP, NSP, progress notes, inventories, education and employment documentation, medical and dental encouragement, and aftercare tracking.
- Implement automated alerts, verification, and monthly internal audits to prevent recurrence.

Section A. Licensure and Certificate of Compliance

Finding

SIR 1 incident on 06 17 2025 submitted 06 20 2025.

SIR 2 incident on 04 22 2025 submitted 04 24 2025.

Root Cause

Staff did not use calendar alerts and did not execute cross reporting immediately. Supervisory review occurred after the submission window.

Corrective Actions

1. Youth Advocate Completes the SIR Immediately Upon Learning the Incident
   - Youth Advocate will complete the SIR the same day they learn the information.
   - Completion is required no later than 12 hours from the time the incident becomes known, ensuring compliance with the Contract's mandate for timely reporting, documentation, and safety responsibilities.
2. Weekly Audits- Regional Director and Executive Team Members will audit all SIRs every week to ensure:
   - Required approvals occurred inside the 24-hour window
   - SIR was submitted timely
   - Documentation is complete and accurate
   - Deficiencies trigger mandatory retraining and corrective steps.
3. Staff Retraining and Monthly Refreshers
   - All staff will receive mandatory retraining on SIR procedures, child safety reporting obligations, and documentation quality standards directly aligned with Child Abuse Reporting requirements and program supervision standards within the Contract.

Owner and Timeline

County Program Managers implement the workflow and alerts by January 15, 2026. Supervisors must enforce the two-level approval, effective immediately.

Measure of Success

100% of SIRs entered and cross reported within required timeframes each month. Zero late SIRs.

Section B 2 Required Training

Finding
S5 completed Involving Law Enforcement training late on 10 20 2025. Hire date 05 06 2025. Training due 08 06 2025.

Root Cause
Training due dates were not visible to staff and supervisors. There was no automated alert and no consequence framework.

Corrective Actions

1. Build a training calendar with due dates at thirty, sixty, and ninety-day intervals and automatic alerts to the staff and supervisor.
2. Lock access to field work after a missed due date until training is complete.
3. Add pre- and post-assessments and store certificates in the digital file.

Owner and Timeline
The Practice and Development team deploys the calendar and access lock by January 22, 2026.

Measure of Success
100% of new-hire training was completed by the due dates. Zero late trainings each quarter.

Section B 3 THPP- NMD Staff Annual Required Training

Finding
35) No - S1 has not submitted any training hours completed. S2 only completed 18.5 hours of annual training based on the Certificates of Completion submitted.

Root Cause

The agency did not maintain a standardized system for tracking staff training in real time. Supervisors did not review staff training progress throughout the year, resulting in missed or incomplete hours. Staff were not assigned individualized training schedules aligned with contract deadlines and required competencies. Training certificates were not consistently uploaded to personnel files or submitted to the reviewer.

Corrective Actions

1. Implement a Comprehensive Annual Training Tracking System

- The Practice and Development team will launch a digital training tracker that logs:
- Required 20 hours
- Completed hours

- Training topics
- Source of training
- Upload verification of certificates
- Dashboard will auto-flag staff who fall below monthly progress benchmarks (minimum 2 hours per month).

2. Supervisor Monthly Training Monitoring

- Supervisors will conduct monthly audits of all staff training hours.
- Supervisors will review and sign a Training Compliance Log verifying each staff member's progress toward the 20-hour requirement.
- Any staff falling more than one month behind will receive a written reminder and a 10-day completion plan.

3. Quarterly Compliance Review by the Regional Director

- Beginning next quarter, the Regional Director will perform quarterly compliance checks to ensure THPP-NMD staff remain on track.
- Non-compliant staff will be placed on a Staff Improvement Plan consistent with Contract expectations for adequate staffing and program oversight.

5. Standardize a Required Annual Training Calendar

- The Practice & Development Department will publish an annual training calendar that includes all required topics listed in the Contract, including:
- Child Abuse Reporting
- Characteristics of TAY
- AB-12/EFC
- Involving Law Enforcement
- Trauma-Informed Care
- Cultural Competency
- CSEC
- LGBTQ+
- All staff will have a signed copy acknowledging their required training deadlines.

6. Mandatory Documentation Procedure

- All training certificates must be:
- Uploaded to the digital personnel file within 24 hours.
- Submitted to the supervisor for verification.
- Logged in the Training Tracker with date, topic, and instructor credentials.

Section C. Contractor and Agency Reports

Finding

A- 27 monthly reports were late for September, October, November, December 2024, and January 2025. February 2025 is missing.
A- 32 report for May 2025 was late. No record for June 2025.

Root Cause

The reporting calendar was maintained manually and did not include receipt verification from CPM. Staff changes disrupted continuity.

Corrective Actions

1. Publish a master reporting calendar with due dates and a two person verification process.
2. Require email submission with read receipt to CPM and store the receipt in a digital folder labeled by month.
3. Reconcile the dashboard with CPM confirmations weekly and address any gaps within two business days.

Owner and Timeline

Clinical Program Managers deploy the calendar and verification by February 15, 2026.

Measure of Success

One hundred percent on time submission and confirmation for A 27 and A 32 every month. Zero missing months.

Section D. THPP NMD Participant Record Folder and Case File

Finding

Multiple participants had late or missing updated TILP. Participants P1, P4, P9, and P10 lacked timely updates. Participants P11, P12, and P13 had missing updates and no documented efforts.

Root Cause

Staff did not maintain a TILP tracking system and did not record outreach attempts to CSW or DPO.

Corrective Actions

1. Implement a TILP tracker that records initial date, due date, outreach attempts, receipt date, and file location.
2. Require documented outreach to CSW or DPO at least three times over fourteen days when an update is due.
3. Escalate to the supervisor on day fifteen and to the Regional Director on day twenty-one.
4. Add the TILP status to weekly supervision agendas until complete.

Owner and Timeline
Clinical Program Managers deploy the tracker by February 16, 2026.

Measure of Success
100% timely TILP updates, with documented outreach when delays occur.

A 20 and NSP

Finding
P2 initial A 20 was late. Multiple NSP issues, including missing updates and missing signatures for P4, P10, P11, and others.

Root Cause
NSP and A 20 lacked a start to finish workflow and signature capture at intake and update.

Corrective Actions

1. Initiate NSP at intake and complete within thirty days of placement.
2. Use electronic signature capture for participants and CSW or DPO.
3. Schedule six month NSP reviews and record signatures.
4. For A 20, require creation within seven days of placement and update monthly.
5. Add a monthly audit to confirm signatures and dates.

Owner and Timeline
Youth Advocates begin the new NSP and A 20 process immediately. Audit begins February 1, 2026.

Measure of Success
100% of NSPs signed and current. 100% of A 20s created and updated on schedule.

Inventories and Progress Reports

Finding
P3 unit and furniture inventory missing. P3 quarterly clothing inventory missing. P10 progress report missing. P2 initial A 20 was created late and submitted late. Quarterly reports for P10, P11, and P13 had missing documents or unknown submission dates.

Root Cause
Inventories and reports were not tied to calendar events and lacked submission receipts.

Corrective Actions

1. Create calendar events for unit inventory and quarterly clothing inventory with due dates and instructions.
2. Require progress reports and quarterly reports to be emailed to CPM with read receipt and stored in the digital file.
3. Add a checklist to the file cover that lists the required items and dates.

Owner and Timeline
Clinical Program Managers must implement by February 20, 2026.

Measure of Success
One hundred percent completion and documentation of inventories and reports each cycle.

Section D-2 Case Management Contact

Finding

Finding 71 – Daily Contact Not Documented

Across participants P1–P15, the agency did not meet the THPP-NMD contract requirement to document daily contact upon initial placement.
Significant gaps in daily contact documentation were found for every participant reviewed, including extended periods of multiple consecutive days, weeks, or months without any recorded contact.
For P13, no daily contact notes were provided, making the compliance status undeterminable.

Finding 72 – No Written Authorization for Reduced Contact

For all participants (P1–P15), the agency did not obtain or document written CSW/DPO authorization before reducing daily contact to the contract-permitted minimum of twice per week.
No evidence of authorization was present in any participant file.

Finding 73 – Weekly Face-to-Face Visits Not Maintained

- Weekly face-to-face contact was not consistently completed or documented for multiple participants. Findings include:
- Entire months with no face-to-face documentation (e.g., P1 missing Feb–Apr 2025).
- Missed weekly visits ranging from single-week gaps to multi-week gaps.
- Incomplete visit details (e.g., P13 missing visit locations).

Finding 74 – Required 60-Minute Weekly Visit Not Completed

The required 60-minute weekly case management visit was missed or not documented across multiple participants. Failures included:

- Consistent weekly visit gaps.
- Multi-week periods without required 60-minute visits (e.g., P10 missed up to five consecutive weeks).
- Incomplete documentation of visit duration and content.

Root Cause
No automated system to track missing daily contact entries, leading to extended gaps across months for several NMDs. Failure to obtain written CSW/DPO authorization prior to reducing daily contacts, despite contract requirements.

Corrective Actions
1. Weekly Compliance Audit by Supervisor during weekly one on one coaching calls with Youth Advocates
Per Youth Advocate's caseload Supervisors must review each NMD's:

- Daily contact logs
- Weekly face-to-face visit logs
- 60-minute visit documentation
- CSW/DPO written authorization status (if applicable)

Any missing documentation must be corrected within 48 hours.

2. Monthly Quality Assurance Review

The Regional Director and Compliance team will:

- Through random selection, audit NMD files monthly for the next 120 days
- Verify contact logs match contract requirements
- Ensure no more than 1 missed daily contact per NMD without documented justification
- Ensure zero reductions in contact occur without written CSW/DPO approval
- Validate weekly in-person visits and visit lengths

3. Progressive Performance Action

Case Managers who miss:

- 3 days of contact, or
- 2 weekly visits, or
- any unauthorized contact reduction
  will be placed on a Corrective Coaching Plan.
- Repeated non-compliance will result in a Staff Improvement Plan and potential reassignment.

Contract Compliance Training

- All staff will attend a mandatory refresher on:
- Exhibit A contact requirements
- Proper documentation

- When and how to obtain CSW/DPO authorization
- New hires must complete this training within 90 days of onboarding.

Owner and Timeline

Clinical Program Managers and Regional Director implement by February 22, 2026.

Measure of Success

100% of participants have a documented daily contact and or approved reduced contact from CSW/DPO in the file.

Section D-3 Permanent Adult Connection and Mentoring

Finding

P5 lacked documentation of identification and maintenance of the Permanent Adult Connection and referral to mentoring.

Root Cause

Permanent Adult Connection planning lacked a structured template and review cadence.

Corrective Actions

1. Add a Permanent Adult Connection plan section to the NSP that identifies the adult connection and concrete engagement steps.
2. Refer participants to a mentoring organization within thirty days of intake and record the referral and follow through.
3. Review connection status monthly and document progress.

Owner and Timeline

Youth Advocates and Clinical Program Managers implement by January 22, 2026.

Measure of Success

100% of participants have a documented Permanent Adult Connection plan and a mentoring referral within 30 days of program entry.

Section E. THPP NMD Participant Training

Finding

Several participants did not meet the minimum requirement of 240 minutes of life skills training per month. Some corrective action plans lacked actionable detail, and some months covered fewer than four topics.

Root Cause

Minutes tracking was manual and reactive. Make up sessions were not scheduled. **Corrective Actions**

1. Deploy a weekly minutes tracker that rolls up to monthly totals and flags shortfalls by the twentieth of each month.
2. Schedule make up sessions in the same month when minutes fall below target.
3. Record topic titles and learning objectives.
4. Use action oriented corrective plans that specify how the youth will regain minutes the following month and how staff will support success.
5. Partner with the Youth Enhancement Services team to align workshops and ensure documentation accuracy.
6. Incorporate the usage of the refundable fines when youth miss the lifeskills training

Owner and Timeline

Social Work Lead and Youth Enhancement Services deploy the tracker and monthly plan by March 19, 2026.

Measure of Success

100% of participants meet for 240 minutes each month. Zero months below target without the following month's make-up.

Section F. Education and Employment

Finding

P10 and P13 lacked documentation of registration with America Job Center of California CalJobs or department initiatives within seven business days.

Root Cause

File did not contain standardized employment verification and job center registration proof.

Corrective Actions

1. Add an employment verification form that captures employer contact, schedule, and monthly hours with pay stubs or supervisor confirmation.
2. Require job center registration within seven business days and store confirmation and login printout.
3. Review employment status at every NSP meeting and update documentation.

Owner and Timeline

Education and Employment Specialists implement immediately. The Education and Employment Manager confirms compliance by January 26, 2026.

Measure of Success

100% of employed participants have verified monthly hours. 100% of unemployed or underemployed participants are registered with the job center within 7 business days.

Section G. Medical and Dental

Finding

For P2, P3, P5, P6, and P8, the agency could not determine if annual medical and dental encouragement occurred. No documentation was provided.

Root Cause

Encouragement and follow through were not documented in progress notes or file checklists.

Corrective Actions

1. Add medical and dental encouragement prompts to monthly check ins with participants and require documentation of the discussion and outcome.
2. Provide appointment assistance and record confirmations and outcomes.
3. Track annual exam dates in the dashboard and flag overdue items.

Owner and Timeline

Clinical Program Managers update workflows by January 15, 2026.

Measure of Success

100% of participants have documented encouragement and outcomes, and annual exams are tracked.

H. Program Exit and Aftercare Follow-Up and Tracking

Finding

For participant D2 the A 31 Exit Assessment and A 20 Termination Report were not submitted. Savings documentation was not provided. Aftercare tracking at thirty and ninety days was not completed, and the A36 Aftercare Contact Form was not provided quarterly.

Root Cause

Exit and aftercare steps lacked a checklist and submission verification to CPM.

Corrective Actions

1. Create an exit checklist that mandates A 31 A 20 savings calculation and verification, and CPM submission with read receipt.
2. Schedule aftercare tracking at thirty and ninety days with contacts logged and the A 36 Aftercare Contact Form submitted each quarter on January 15, April 15, July 15, and October 15.
3. Require supervisor review of the exit package before submission and audit aftercare compliance monthly.

Owner and Timeline
Clinical Program Managers implement the checklist by February 12, 2026. Aftercare schedule begins immediately for all current exits.

Measure of Success
100% of exit packages are complete and submitted on time. 100% of aftercare tracking was completed at 30 and 90 days, with timely A36 submissions.

Overall Training and Communication

1. Deliver mandatory refresher training on this corrective plan to all staff by February 1, 2026.
2. Provide quick reference guides that outline steps, due dates, and required evidence for SIR, A 27, A 32, TILP, NSP, A 20, A 31, A 36, inventories, progress reports, life skills minutes, employment documentation, and medical and dental documentation.
3. Review compliance status in weekly supervision and in the monthly leadership meetings.

Respectfully,
[redacted]
Regional Director of Programs, SoCal
First Place for Youth | More is Possible