



County of Los Angeles

DEPARTMENT OF CHILDREN AND FAMILY SERVICES

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May 29, 2026

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

From: [Signature] for
Brandon T. Nichols
Director

HERMANITOS UNIDOS – SIBLINGS UNITED FOSTER FAMILY AGENCY
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 the Hermanitos Unidos – Siblings United Foster Family Agency (FFA) in February 2026. This Contractor has one site located in the Fifth Supervisorial District. The site provides services to the County of Los Angeles DCFS placed children, Probation foster youth, and Non-Minor Dependents (NMDs) and children placed by other counties.

Key Outcomes

Table with 4 rows: NUMBER OF PRIORITY FINDINGS, PRIORITY 1 (5), PRIORITY 2 (11), PRIORITY 3 (1)

The CCD 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 and Transition Services, Education and Independent Living Plan 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 6 of 11 applicable areas of CCD's Contract Compliance Review: RFH Requirements; Permanency and Transition Services; Education and Independent Living Plan Services; Personal Rights and Social/Emotional Well-Being; Personal Needs/Survival and Economic Well-Being; and Personnel Files.

For the purpose of this review, four DCFS placed children and two NMDs were selected for the sample. The CCD reviewed the files of the six children and NMDs and interviewed two children and two NMDs to assess the level of care and services they received. Two children (ages 1 and 3) were too young to be interviewed and were virtually observed to be clean and well-groomed. An additional four discharged children and youth files were reviewed to assess the Contractor's compliance with permanency efforts. The CCD reviewed three RFH files and four staff files for compliance with Title 22 Regulations and County contracting requirements. The CCD also conducted virtual interviews with staff and Resource Family Parents (RFP). To assess the quality of care and supervision provided to the placed children and foster youth. DCFS also conducted virtual site visits of the RFHs.

The CCD noted findings in the following areas:

Priority 1

- General Contract Requirement (3 Findings)
 - Special Incident Reports for three children were not properly cross-reported in the I-Track system.
- Facility and Environment (2 Findings)
 - One RFH did not properly store disinfectants, laundry detergent products and other cleaning solutions.
 - One RFH did not ensure that the children's bedroom had a safe and direct emergency exit to the exterior of the home.

Priority 2

- Facility and Environment (1 Finding)
 - One RFH did not ensure the yard and outdoor activity space were free from safety hazards.
- Engagement and Teamwork (2 Findings)
 - The Contractor did not document efforts to collaborate and participate in the Child and Family Team (CFT) meetings or obtained copies of the CFT meeting notes for one NMD.
 - One NMD's Needs Services Plans were in alignment with services as

identified in the CFT notes.

- Needs and Services Plans (6 Findings)
 - The Needs Services Plans for four children and two NMDs were not developed timely, comprehensively and accurately and timely signed by the children and NMDs.
- Health and Medical Needs (2 Findings)
 - Required follow-up medical examination was not conducted on time for one child.
 - The court approved psychotropic medication authorization for one child was not in file.

Priority 3

- Needs and Services Plans (1 Finding)
 - The Need Services Plan for one NMD was not consistent with the Transitional Independent Living Program plan.

On March 17, 2026, the DCFS' CCD Children Services Administrator teams 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) 371-6052.

BTN:LM:RT
KR:DF:gt

Attachments

c: Joseph M. Nicchitta, Acting Chief Executive Officer
Oscar Valdez, Auditor-Controller
Guillermo Viera Rosa, Chief Probation Officer
Public Information Office
Audit Committee
Joseph Steinberg, Chief Executive Officer, Hermanitos Unidos- Siblings United FFA
Kellee Coleman, Assist Program Administrator, LA Region CCLD
Bernice Karnsrithong, Regional Manager, Community Care Licensing Division
Jacqueline Juarwz, Acting CDSS Bureau Chief Fiscal and Performance Audits



LOS ANGELES COUNTY
HERMANITOS UNIDOS - SIBLINGS UNITED FFA (FFA)

Corrective Action Plan

2026

GENERAL CONTRACT REQUIREMENTS

1. Special Incident Reports are properly documented.

1b. Properly cross-reported in the I-Track system [SOW, Part B, Section 10.4 and SOW Exhibit A-5, Special Incident Reporting Guide][SOW, Part B, Section 10.4 and SOW Exhibit A-5, Special Incident Reporting Guide.](#)

Facility

Site 1843

Site 1843

Site 1841

1. Explain the Cause.

The delay in cross-reporting three Special Incident Reports (SIRs) in the I-Track system resulted from gaps in internal communication, inconsistent monitoring of reporting timelines, and staff misunderstanding of the required steps for completing a cross-report under SOW Part B, Section 10.4 (Agency was mistakenly going by state standard of “one business day”, as all of these occurred on Friday or Saturday and were reported on Monday). In several cases, SIRs were initiated promptly, but the final step—entering the cross-report into I-Track within the mandated timeframe—was overlooked or completed late. Contributing factors included competing caseload pressures, reliance on memory rather than automated prompts, and an absence of a dedicated compliance checkpoint prior to SIR submission.

2. Corrective Action Taken.

To prevent recurrence, the agency implemented a structured, multi-layered corrective plan: - Re-Training on SOW Requirements: All social workers and supervisory staff will receive refresher training specifically addressing I-Track workflow, mandatory cross-report timeframes, and SOW Part B, Section 10.4 expectations. Training shall include real-case examples and step-by-step demonstrations. Training will be completed by Administrator by June 1, 2026. - I-Track Reporting Checklist: A required SIR Cross-Reporting Checklist was created and must now be attached to every SIR submission. This checklist includes verification of: - SIR submission date - Required notifications completed - Cross-report entry completed in I-Track - Supervisor sign-off - Automated Reminder System: The agency created internal digital reminders that notify assigned staff and supervisors when a cross-report has not been entered into I-Track within 12 hours of the SIR creation, ensuring immediate follow-up before the deadline is missed. - Supervisor Review Requirement: Supervisors must now confirm I-Track cross-report completion before approving any SIR. No report can be finalized in the internal system until the cross-report is completed and verified.

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

To ensure sustained compliance: - Weekly QA Audits of All New SIRs: QA staff will review every SIR submitted during the week to ensure cross-reports were completed within the required timeframe. Any delay will be documented and addressed with immediate corrective coaching. - Monthly Compliance Tracking Report: A monthly performance excel format that will track SIR timeliness, cross-report completion, and staff-specific compliance rates. Patterns or repeat delays will trigger additional training or corrective action. - Quarterly Policy Review: Every quarter, QA, Supervisors, and the Administrator will review SIR workflow, timelines, and reporting expectations to ensure no gaps re-emerge and to adjust procedures as needed. - Accountability Measure: Staff with repeated late cross-reports will receive individualized supervision plans that include targeted training and performance monitoring. The plan shall be fully implemented by June 1, 2026, and this shall be ensured by both the administrator and supervisor.

FACILITY AND ENVIRONMENT

14. Exterior and grounds of the RFH were safe and well maintained

14d. Yard and outdoor activity space are free from safety hazards ILS 88487.2 (a) (1); Title 22 89387 (h) [ILS 88487.2 \(a\) \(1\)](#); [Title 22 89387 \(h\)](#)

Facility

Site 1843

1. Explain the Cause.

Safety hazards; including unsecured cleaning solutions, improper storage of hazardous items, and partially blocked emergency exits, were not identified during routine and unannounced inspections. The underlying issue stemmed from inconsistent safety practices and limited reinforcement of household safety standards.

2. Corrective Action Taken.

The agency developed a comprehensive RFH Safety Checklist to ensure consistency during visits. RFPs shall be retrained on safe storage, household organization, and emergency exit accessibility. Training shall be completed by June 1, 2026 by administrator. Follow up inspections were scheduled to verify corrections and provide ongoing coaching to maintain safe environments.

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

Inspectors now use standardized checklists to ensure consistent assessment across all RFHs. QA staff shall review submitted checklists monthly and verify that hazard corrections are documented and completed. Homes with repeat deficiencies will receive increased monitoring and additional support. The plan shall be fully implemented by June 1, 2026, and that shall be ensured by the administrator and supervisor.

15. Common areas were safe and well-maintained

15k. Disinfectants, cleaning solutions, poisons, firearms and other dangerous items are not accessible to children Title 22 80087(g), 84067 [Title 22 80087\(g\)](#), [84067](#)

Facility

Site 1843

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17. Children's bedrooms were safe and well maintained ILS 88487.1(b)(2) and (c) (1) and (b)(3)

17k. Each bedroom has at least one operable window or door to ensure safe and direct emergency exit to the exterior of the home (Title 22 84072(c)(14)) and [ILS §88487.1(b)(1)](Title 22 84072(c)(14)) and [ILS §88487.1(b)(1)]

Facility

Site 1843

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The agency developed a comprehensive RFH Safety Checklist to ensure consistency during visits. RFPs shall be retrained on safe storage, household organization, and emergency exit accessibility. Training shall be completed by June 1, 2026 by administrator. Follow up inspections were scheduled to verify corrections and provide ongoing coaching to maintain safe environments.

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

Inspectors now use standardized checklists to ensure consistent assessment across all RFHs. QA staff shall review submitted checklists monthly and verify that hazard corrections are documented and completed. Homes with repeat deficiencies will receive increased monitoring and additional support. The plan shall be fully implemented by June 1, 2026, and that shall be ensured by the administrator and supervisor.

ENGAGEMENT AND TEAMWORK

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 1842

1. Explain the Cause.

Agency participation in Child and Family Team (CFT) meetings was not consistently documented, resulting in incomplete records regarding agency involvement, coordination with county partners, and follow-up on identified action items.

2. Corrective Action Taken.

No later than June 1, 2026, agency leadership will formally notify all staff of clarified expectations regarding Child and Family Team (CFT) participation and documentation requirements. On that date, staff will be assigned specific responsibilities for attending required CFT meetings, obtaining and retaining meeting notes, and documenting all efforts in the child's record, including attempted contacts and coordination efforts with Los Angeles County DCFS and other team members. A structured CFT attendance log shall be introduced by June 1, 2026, to ensure consistent tracking of required participation, meeting dates, attendees, action items, and follow-up responsibilities in alignment with Los Angeles DCFS CFT practice standards.

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

CFT attendance logs and related documentation will be maintained in each child's file and reviewed monthly as part of the agency's Quality Assurance process. QA staff will verify that CFT meeting participation, meeting notes, assigned action items, and documented follow-up activities are complete, timely, and consistent with Los Angeles DCFS expectations and agency policy. The plan shall be fully implemented by June 1, 2026, and this shall be ensured by administrator and supervisor.

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 1842

1. Explain the Cause.

NSPs did not consistently reflect the decisions, services, and recommendations identified during CFT meetings. This misalignment resulted from delays in transferring CFT information into case planning documents.

2. Corrective Action Taken.

Staff shall receive targeted training on integrating CFT outcomes into NSPs promptly and accurately. Training shall be completed by administrator by June 1, 2026. Additional guidance was provided to ensure NSP updates reflect the most recent child needs, recommendations, and team decisions.

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

During monthly reviews, QA staff will compare active NSPs with recent CFT notes to ensure full alignment. Any discrepancies will require immediate updates by assigned staff. This shall be implemented by June 1, 2026, and this shall be ensured by both the administrator and supervisor.

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 1842
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23b. Are comprehensive and accurate

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Site 1843
Site 1843

23d. Signed by children when age or developmentally appropriate

Facility
Site 1842

1. Explain the Cause.

Several NSPs lacked timely updates, child signatures, and critical LA DCFS required documentation. These gaps occurred due to inconsistent scheduling, unclear staff responsibilities, and a lack of automated reminders for required updates.

2. Corrective Action Taken.

The agency established a structured NSP timeline with automated reminders for due dates, revisions, and required signatures. Staff shall be retrained by administrator by June 1, 2026 on documentation standards, with emphasis on developmental appropriateness for child signatures, and include specific dates for all medical appointments, birth visits, and therapy visits. Caseworkers now receive clearer guidance on incorporating mandated LA DCFS elements.

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

QA will conduct monthly audits to ensure NSPs are current, accurate, and consistent with recent CFT notes. Any missing elements will be identified promptly, and corrective actions will be addressed within the same review cycle. The plan shall be fully implemented by June 1, 2026, and this shall be ensured by both the administrator and supervisor.

27. NSPs for non-minor dependents are consistent with the Transitional Independent Living Program (TILP) plan, or the FFA has documented efforts to obtain the TILP (SOW, Part C, Section 19.0)

Facility

Site 1842

1. Explain the Cause.

The finding occurred because the Non-Minor Dependent's (NMD's) most recent Needs and Services Plan (NSP) was updated without fully incorporating the goals outlined in the approved Transitional Independent Living Plan (TILP). Specifically, required TILP goals related to independent living skills, education and employment planning, and transitional objectives were not clearly reflected in the NSP, resulting in inconsistency between required case planning documents for the NMD.

2. Corrective Action Taken.

Following identification of the finding, agency staff shall review the affected case and update the NMD's NSP to ensure that all current TILP goals were accurately included and aligned. Staff shall be provided clarification regarding Los Angeles County DCFS requirements that NSPs for children and Non-Minor Dependents must be consistent with, and supportive of, the approved TILP. Effective no later than June 1, 2026, case-carrying staff shall be required to review the most current TILP prior to completing or updating any NSP to ensure alignment of education, employment, housing readiness, life skills development, and permanency goals.

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

To maintain compliance, the agency's Quality Assurance (QA) process will include monthly reviews of NSPs for children and Non-Minor Dependents to verify consistency with the corresponding TILP. QA reviewers will confirm that TILP goals are current, clearly incorporated into the NSP, and supported by identified services. Any discrepancies identified will require prompt correction, supervisory review, and updated documentation to ensure sustained compliance with Los Angeles County DCFS planning requirements. The plan shall be fully implemented by June 1, 2026, and this shall be ensured by administrator and supervisor.

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 1843

1. Explain the Cause.

The finding occurred because documentation for required medical and dental follow-up exams was not consistently maintained in several child files. Contributing factors included fragmented communication among Assigned Social Workers (ASWs), Resource Family Providers (RFPs), and medical and dental providers, as well as the absence of a centralized tracking system to monitor appointment completion, follow-ups, and timely filing of required documentation. This resulted in delayed verification and incomplete records.

2. Corrective Action Taken.

A centralized medical tracking log shall be implemented no later than June 1, 2026, to monitor required medical and dental appointments, follow-up timeframes, and pending documentation for all children. The assigned ASW is responsible for ensuring that all required medical and dental appointments are scheduled and completed by coordinating with RFPs and confirming attendance and follow-up care. The ASW is responsible for tracking appointments in the centralized log, obtaining and verifying all medical and dental documentation (including after-visit summaries, exam reports, and follow-up notes), and ensuring documents are filed in the child's record. To support consistent implementation, staff training on the medical tracking log and updated medical follow-up procedures will be conducted no later than June 1, 2026.

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

As part of the agency's ongoing Quality Assurance process, QA staff will review the centralized medical tracking log and corresponding child files every 30 days to confirm that required medical and dental appointments are completed and documentation is timely and complete. QA Staff will verify compliance with follow-up requirements and coordination efforts. Any discrepancies will result in immediate corrective action, including follow-up by the Q & A Compliance staff, guidance to ASWs, and supervisory oversight to ensure sustained compliance with Los Angeles County DCFS requirements. The plan shall be fully implemented by June 1, 2026, and this shall be ensured by administrator and supervisor.

46. Current court-approved psychotropic medication authorizations are on file, or FFA has documented efforts (Contract, Sections 19.1, SOW Part C, Sections 15.1.1, ILS Sections 88487.16(g))

Facility

Site 1843

1. Explain the Cause.

The finding occurred because required court-approved authorization for psychotropic medications (JV-220 / JV-223) was not consistently present in some child files. This was due to inconsistent communication and follow-up with Children's Social Workers (CSWs) regarding court submission and approval status, as well as the absence of a formal system to track authorization approvals and renewal due dates. As a result, documentation verifying court approval for prescribed psychotropic medications was incomplete at the time of review.

2. Corrective Action Taken.

The agency will implement a psychotropic medication authorization tracking system to monitor submission, court approval, and renewal timelines for all JV-220 / JV-223 requests no later than June 1, 2026. Assigned staff will then be required to actively follow up with CSWs regarding the status of court-approved psychotropic medication authorizations (PMA) and to document all communication and outcomes in the child's record. Staff shall be retrained on psychotropic medication regulations, documentation requirements, and communication expectations with placing agencies and CSWs to ensure timely authorization and proper filing of PMA documentation by administrator, by June 1, 2026. Case-Specific Update - Child C5: Following identification of the finding, additional follow-up was completed with the assigned CSW regarding Child C5's court-approved psychotropic medication authorization (PMA)(see attached second attempt). The status of the authorization is in process, and the appropriate court-approved JV-220 / JV-223 documentation shall be obtained and filed in the child's record, ensuring current compliance with court requirements.

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

Quality Assurance (QA) staff will conduct monthly psychotropic medication file reviews to verify that court-approved JV-220 / JV-223 authorizations are current, properly documented, and consistent with prescribed medications. QA will confirm that renewal dates are tracked and that follow-up with CSWs is documented. Any missing or expired authorizations will prompt immediate corrective action, including follow-up with CSWs, providers, and supervisory oversight to maintain ongoing compliance with Los Angeles County DCFS requirements. The plan shall be fully implemented by June 1, 2026, and this shall be ensured by administrator and supervisor.