County of Los Angeles
DEPARTMENT OF CHILDREN AND FAMILY SERVICES
510 S. Vermont Avenue, Los Angeles, California 90020
(213) 351-5602

LISA E. MANDEL
Interim Director

JENNIE FERIA
Chief Deputy Director

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

October 8, 2026

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

From: for
Lisa E. Mandel
Interim Director

DAVID AND MARGARET HOME FOSTER FAMILY AGENCY CONTRACT COMPLIANCE REVIEW REPORT

The Department of Children and Family Services (DCFS) Contract Compliance Division (CCD) conducted a virtual Contract Compliance Review of the David and Margaret Home doing business as David and Margaret Youth and Family Services Foster Family Agency (FFA) in May 2026. The Contractor has two offices: one located in the First Supervisorial District, and one located in the Fifth Supervisorial District. The offices provide services to the County of Los Angeles DCFS placed children, Probation foster youth, Non-Minor Dependents and children placed by other counties.

Key Outcomes

NUMBER OF PRIORITY FINDINGS
PRIORITY 1 1
PRIORITY 2 8
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 (NSPs); 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 8 of 11 applicable areas of the CCD's Contract Compliance Review: General Contract Requirements; RFH Requirements; 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.

For the purpose of this review, six DCFS placed children were selected for the sample. The CCD reviewed the files of the six children and virtually interviewed two children to assess the level of care and services they received; two children (ages 9 months, and 2 years) were too young to be interviewed and were virtually observed to be clean and well-groomed. Two children (ages 8 months, and 2 years) were replaced with another Approved Resource Home within the FFA prior to the RFH inspection. An additional four discharged children's files were also 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 telephonic and virtual interviews with staff and Resource Foster Parents 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

- Facility and Environment (1 Finding)
    - Common areas were not safe and well maintained; there was a discrepancy in the number of firearms reported by one RFH at the time of the virtual walkthrough and what was documented and confirmed by the FFA Contractor in the Resource Parent Weapons Agreement.

Priority 2

- Engagement and Teamwork (2 Findings)
    - The Contractor did not document efforts to collaborate and participate in the Child and Family Team (CFT) meetings and did not obtain request copies of the CFT meeting notes for two children.

- Needs and Services Plan (6 Findings)
    - The NSPs for six children were not developed timely, were not comprehensive or accurate and were not signed timely by the Contracted FFA.

Priority 3

- Facility and Environment (1 Finding)
    - One RFH vehicle used to transport children was not in good repair. The vehicle tire pressure light was on during virtual inspection.

On June 17, 2026, DCFS' CCD Children Services Administrator team and 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.

LEM:RT
KR:DF:ra

Attachments

c: Joseph M. Nicchitta, Chief Executive Officer
Oscar Valdez, Auditor-Controller
Guillermo Viera Rosa, Chief Probation Officer
Public Information Office
Audit Committee
Daniel S Maydeck, President & Chief Executive Officer, David and Margaret Home
Kellee Coleman, Assist Program Administrator LA Region, CCLD
Bernice Karnsrithong, Regional Manager, Community Care Licensing Division
Jacqueline Juarez, CDSS Bureau Chief Fiscal and Performance Audits

LOS ANGELES COUNTY

DAVID & MARGARET HOME, INC. (FFA)

Corrective Action Plan

2026

FACILITY AND ENVIRONMENT

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

13r. Free of Damage(Title 22 80074(c) & 87074(d))

Facility
Site 1907

1. Explain the Cause.

The Agency had an existing protocol requiring vehicles used to transport children to be maintained in safe working condition and requiring vehicle safety concerns, including dashboard warning indicators, to be promptly addressed. In this instance, the existing protocol was not followed when the vehicle had low tire pressure, the tire-pressure warning light was visible, and the condition was not immediately corrected when the warning light came on. The Agency's review also identified an opportunity to strengthen the existing process by reinforcing vehicle-safety expectations and increasing monitoring between scheduled vehicle inspections. Although the Agency required quarterly vehicle safety reviews and annual inspections by a certified mechanic, vehicle conditions can arise between scheduled reviews. Therefore, the Agency determined that additional monitoring and documentation processes were needed to support consistent adherence to the existing vehicle-safety protocol.

2. Corrective Action Taken.

Immediately, the resource parents added air to the tire and verified that the tire-pressure warning light turned off, correcting the immediate vehicle-safety concern. On 6/30/26, Agency Director reinforced to staff through in person training that the existing vehicle-safety protocol, including the requirement that vehicles used to transport children must be maintained in safe working condition and that dashboard warning indicators or other signs of an unsafe vehicle condition must be promptly addressed. Agency staff were instructed that a vehicle with a warning indicator or other identified safety concern that could affect safe operation is not to be used to transport children until the condition has been corrected and verification has been provided, as applicable. Effective 7/1/26, the Agency expanded its vehicle-safety monitoring process. In addition to the vehicle check completed as part of the Quarterly Home and Safety Checklist, Agency staff will assess vehicle working condition and safety during one randomly selected home visit per quarter. The timing of the random check will vary throughout the quarter. Additionally, visitation monitors will complete one vehicle working-condition and safety check per quarter when resource parents transport children to or from monitored visits, when applicable. Agency social workers will retrain resource parents regarding vehicle-safety requirements, including maintaining vehicles in safe operating condition, promptly responding to dashboard warning indicators, and ensuring that identified safety concerns are corrected before the vehicle is used to transport children. Completion of the retraining will be documented in a family case note no later than 8/31/26. The Agency will continue to require annual vehicle inspections by a certified mechanic each February.

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

Vehicle safety will be monitored through the existing Quarterly Home and Safety Checklist, supplemented by one random vehicle-safety check per quarter during a home visit. When applicable, visitation monitors will provide an additional monitoring point by completing one vehicle-safety check per quarter when resource parents transport children to or from monitored visits. Annual certified-mechanic vehicle inspections will continue to be required each February. The FFA office will maintain a centralized tracking process to monitor completion of required vehicle-safety checks and annual inspections and to identify missing documentation, identified vehicle-safety concerns, required corrective actions, repair or correction verification, and outstanding follow-up. Supervisory and/or designated compliance staff will review the tracking information on an ongoing basis to identify overdue inspections, missed vehicle checks, unresolved safety concerns, or missing corrective-action documentation. Any identified deficiency will be communicated to the responsible Agency staff for timely follow-up and resolution. The Agency will also review vehicle-safety findings for patterns or recurring compliance concerns. When trends are identified, the Agency will implement additional corrective measures as appropriate, including retraining, increased monitoring, supervisory follow-up, or clarification of agency procedures.

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), 84067Title 22 80087(g), 84067

Facility
Site 1908

1. Explain the Cause.

The Agency had an existing protocol requiring weapons and ammunition in a resource home to be disclosed, documented on the Resource Parent Weapons Agreement, and maintained in accordance with applicable safe-storage requirements. The existing protocol was not fully followed because the Weapons Agreement documented the types of firearms present but did not document the quantity of each type, and the Agency's verification process did not identify and correct the incomplete information. The Agency's review determined that the existing process did not provide sufficiently specific steps requiring Agency staff to visually verify and reconcile the number and type of weapons and ammunition present in the home against the information documented on the Weapons Agreement. The process also did not clearly establish when a new Weapons Agreement was required following the acquisition, observation, or reporting of an additional weapon. As a result, the Weapons Agreement remained incomplete regarding the quantity of firearms present even though the firearms were appropriately secured in a locked gun safe. The Agency identified the primary process issue as the need for a more clearly defined verification, documentation, and ongoing monitoring procedure to ensure the Weapons Agreement remains complete, accurate, and current

2. Corrective Action Taken.

On 5/30/26, the Agency completed a visual verification of all firearms in the resource home and confirmed that 18 firearms—10 handguns, 2 shotguns, and 6 rifles—were stored in a locked gun safe. The Weapons Agreement was corrected to accurately document the number and types of firearms present, and supporting documentation was obtained. The requirements for accurate disclosure, documentation, and secure storage of weapons and ammunition were also reinforced. On 6/30/26, the Agency Director trained Agency staff regarding the proper documentation and storage of weapons and ammunition in resource homes. Training included the requirement for staff to visually verify the number, type, and proper storage of weapons and ammunition and reconcile the information observed with the current Weapons Agreement. Effective 7/1/26, the Agency expanded its monitoring process. In addition to the weapons and ammunition storage review completed through the Quarterly Home and Safety Checklist, Agency staff will verify weapons and proper storage against the current Weapons Agreement during one randomly selected home visit per quarter for homes reporting weapons or ammunition. The Agency also revised its process to require completion of a new Weapons Agreement whenever a new weapon is observed or reported and annually, at minimum, to ensure the documented inventory remains current. All resource parents, whether or not weapons or ammunition are present in the home, will complete a new Weapons Agreement and receive retraining regarding weapon and ammunition disclosure, documentation, reporting, and secure-storage requirements no later than 8/31/26. Completion will be documented in a family case note in the Agency's electronic record.

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

For homes reporting weapons or ammunition, Agency staff will continue to verify proper storage through the Quarterly Home and Safety Checklist. Effective 7/1/26, this process will be supplemented by one randomly selected home visit per quarter during which Agency staff will visually verify the number and type of weapons and ammunition and reconcile the information observed with the current Weapons Agreement. A new Weapons Agreement will be completed whenever a new weapon is observed or reported and annually, at minimum. Agency staff will review the agreement for completeness and ensure that the documented number and type of weapons correspond with the verified inventory. The FFA office will maintain a centralized tracking process to monitor required Weapons Agreements, annual updates, quarterly and random verification checks, identified discrepancies, missing or inconsistent documentation, and required follow-up. Any discrepancy between the Weapons Agreement and the weapons or ammunition verified in the home will require documented follow-up and correction. If access to a weapon-storage area prevents verification during a scheduled monitoring activity, Agency staff will arrange timely follow-up so that the number, type, and secure storage of all weapons and ammunition can be visually verified. Verification will be completed through an appropriate method that allows the Agency to confirm compliance while maintaining necessary confidentiality and security. Supervisory and/or designated compliance staff will review tracking information on an ongoing basis to identify missing or outdated Weapons Agreements, incomplete verification, discrepancies between documented and observed weapons, or unresolved follow-up items. Identified deficiencies will be assigned for timely correction and monitored through resolution. The Agency will periodically review monitoring findings for patterns or recurring compliance concerns. When trends are identified, additional corrective measures may include targeted retraining, increased monitoring, supervisory follow-up, or clarification of Agency procedures.

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 1907
Site 1908

1. Explain the Cause.

The Agency had an existing protocol requiring timely collaboration with the County Children's Social Worker regarding Child and Family Team Meetings (CFTMs), including documented efforts to support an initial CFTM within 60 days of placement and every 90 days thereafter. The Agency's process also required at least three requests for a CFTM during each 90-day period, documentation of requests and participation efforts, maintenance of the CFTM matrix, and supporting documentation in the Agency electronic record. The existing protocol was not consistently followed. For one child, timely documented efforts were not available to demonstrate compliance with the initial 60-day requirement. For the second child, the documented request for CFTM collaboration occurred approximately six months after the prior CFTM rather than within the required 90-day timeframe. In addition, some CFTM requests reported as having been made were not documented, preventing the Agency from demonstrating that required efforts occurred timely. The Agency's review identified that the existing process relied primarily on assigned Agency social workers to independently track CFTM due dates, requests, CFTM matrices, and supporting documentation without a sufficiently structured secondary monitoring process. As a result, missing or late requests and documentation were not consistently identified before required compliance timeframes elapsed.

2. Corrective Action Taken.

On 6/30/26, Agency social workers were retrained by Agency Director on CFTM requirements, including timely collaboration and requests for CFTMs, required timeframes, documentation of all requests and follow-up efforts, and maintenance of supporting documentation in the Agency electronic record. The Agency established a dedicated compliance social worker to provide secondary oversight of CFTM compliance rather than relying solely on assigned Agency social workers to independently track required timeframes and documentation. The Agency implemented a centralized monthly monitoring process to verify that each child has a documented CFTM request or written verification that a CFTM has been scheduled. The process also separately tracks receipt of the CFTM matrix within the initial 60-day period and every 90 days thereafter, as well as documented efforts to obtain any missing CFTM matrix. The Agency established an escalation process requiring the compliance social worker to notify the assigned Agency social worker and Director when a CFTM has not been requested by the third week of the month, allowing corrective action to occur before required timeframes are missed. If a required CFTM matrix is not received within the applicable quarter, the matter will also be escalated to the assigned Agency social worker and Director for follow-up. Compliance is tracked through a centralized spreadsheet and verified against supporting documentation maintained in the Agency electronic record. Agency social workers will also receive additional CFTM training provided by OHCMD, Lilia Gonzalez by 10/1/2026.

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

Each month, the compliance social worker will review all applicable cases to verify that required CFTM collaboration efforts are occurring within established timeframes. The review will confirm that each child has documented evidence of a CFTM request or written verification that a CFTM has been scheduled and that supporting documentation is maintained in the Agency electronic record. The centralized tracking process will monitor the initial 60-day CFTM timeframe and each subsequent 90-day timeframe, including required requests, scheduled CFTMs, completed CFTMs, receipt of CFTM matrices, requests for missing matrices, and required follow-up. If the required CFTM request or verification of a scheduled CFTM is not documented by the third week of the month, the compliance social worker will notify the assigned Agency social worker and Director for immediate follow-up. This provides an opportunity for corrective action before the applicable compliance timeframe expires. The compliance social worker will also verify receipt and maintenance of the CFTM matrix within the required timeframe. If a matrix has not been received, documented requests to obtain the matrix will be tracked. If the matrix remains outstanding within the applicable quarter, the compliance social worker will escalate the matter to the assigned Agency social worker and Director for additional follow-up. The FFA office will maintain a centralized tracking spreadsheet and supporting records of CFTM requests and follow-up efforts. Information recorded on the tracking tool will be verified against documentation uploaded to the Agency electronic record to ensure the Agency can demonstrate both timely action and documentation of the action taken.

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 1909
Site 1908
Site 1909

23b. Are comprehensive and accurate

Facility
Site 1909
Site 1909
Site 1907
Site 1908
Site 1909
Site 1909

23f. Signed by FFA staff

Facility
Site 1909
Site 1908
Site 1909

1. Explain the Cause.

The Agency had an existing protocol requiring Needs and Services Plans (NSPs) to be completed, signed, and submitted timely according to the due date identified in PMIS. The protocol also required NSPs to contain complete and accurate information, detailed assessment of the child's current needs, individualized S.M.A.R.T. goals, clearly identified services and interventions, documentation of progress and barriers, and a permanency goal consistent with the current DCFS case plan. The existing protocol was not consistently followed. Some NSPs were completed, signed, and/or submitted after the required due date. In addition, some NSPs contained incomplete or inaccurate information, insufficiently detailed sections, goals that were not individualized or S.M.A.R.T., repeated information from prior NSPs without adequate reassessment or updating, unclear services or interventions, insufficient documentation of progress and barriers, and/or permanency goals that did not accurately reflect the current DCFS case plan goal. The Agency's review also identified that the existing review process did not consistently identify timeliness and substantive quality deficiencies before NSP submission. The process required stronger secondary oversight to ensure that NSPs were reviewed not only for completion and due dates, but also for completeness, accuracy, individualized case planning, measurable goals, documented progress and barriers, and alignment with the DCFS permanency goal.

2. Corrective Action Taken.

On 7/21/26, Agency social workers received retraining from OHCMD, Lilia Gonzalez, regarding NSP requirements. The Agency reinforced expectations for the timely completion, required signatures, and submission of NSPs, as well as requirements for complete, accurate, individualized, and sufficiently detailed case-planning documentation. Agency social workers were instructed that NSP goals must be developed using the S.M.A.R.T. framework—Specific, Measurable, Achievable, Relevant, and Time-Based—and must directly address each child's identified needs or problems. NSPs must clearly identify the services and interventions that will be provided and include measurable indicators that allow the child's progress or lack of progress to be evaluated. The Agency also reinforced that each subsequent NSP must document the child's progress toward each goal since the previous NSP, identify barriers affecting achievement of the goal, and reflect changes to services or interventions when appropriate. Goals, services, interventions, and narrative information from a prior NSP are not to be repeated without reassessment and updates that reflect the child's current needs, circumstances, progress, and barriers. Agency social workers were further instructed to verify that the permanency goal documented in each NSP accurately reflects the current DCFS case plan goal, including Family Reunification, Adoption, Legal Guardianship, PPLA, or another applicable DCFS permanency goal. The Agency strengthened its NSP review process to monitor both timeliness and substantive quality, including due dates, required signatures, completeness and accuracy of information, S.M.A.R.T. goal development, linkage of goals to identified needs, services and interventions, documentation of progress and barriers, updates from the prior NSP, and alignment of the permanency goal with the current DCFS case plan.

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

The FFA office will routinely monitor upcoming NSP due dates to ensure NSPs are completed, required signatures are obtained, and plans are submitted within required timeframes. Upcoming and overdue NSPs will be tracked, and any item at risk of being late will be identified for follow-up and escalation before the required due date. As part of the quality-review process, NSPs will be reviewed to verify: Required sections are complete, accurate, and sufficiently detailed to reflect the child's current needs and circumstances. Goals are individualized, directly related to identified needs or problems, and meet the S.M.A.R.T. framework. Services and interventions clearly identify how the child's needs and goals will be addressed. Measurable indicators are included so progress or lack of progress can be evaluated. Progress toward each goal since the previous NSP and any barriers affecting progress are clearly documented. Goals, services, interventions, and narrative information have been reassessed and updated rather than carried forward from the prior NSP without appropriate review. The permanency goal accurately reflects the current DCFS case plan goal. Required signatures and submission requirements are completed timely. The FFA office will monitor upcoming and overdue NSPs and follow up on identified deficiencies. When an NSP is identified as late, incomplete, inaccurate, or not meeting required quality standards, the deficiency will be communicated for timely correction and tracked through resolution. Completed NSPs and required supporting documentation will be verified as maintained in the Agency electronic record. The QA process will monitor both whether the NSP was completed on time and whether the content meets required case-planning standards, recognizing that timely submission alone does not demonstrate compliance if the NSP is incomplete, inaccurate, or insufficiently individualized. The Agency will review QA findings for recurring trends involving late completion or signatures, incomplete documentation, non-S.M.A.R.T. goals, insufficient progress or barrier documentation, repeated content, unclear services or interventions, or incorrect permanency goals. Identified trends will be addressed through additional coaching, retraining, supervisory follow-up, or increased review as appropriate.