REPORT OF THE

OFFICE OF THE AUDITOR GENERAL

TO THE

JOINT LEGISLATIVE AUDIT COMMITTEE

003.1

IMPROVEMENTS WARRANTED IN LICENSING OF RESIDENTIAL CARE FACILITIES FOR CHILDREN

SEPTEMBER 1980

California Legislature

Joint Legislative Audit Committee

GOVERNMENT CODE SECTION 10500 et al

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September 15, 1980

The Honorable Speaker of the Assembly
The Honorable President pro Tempore of the Senate
The Honorable Members of the Senate and the
Assembly of the Legislature of California

Members of the Legislature:

Your Joint Legislative Audit Committee respectfully submits the Auditor General's report concerning the licensing of residential care facilities by the Community Care Licensing Division of the Department of Social Services.

The auditors are Robert E. Christophel, Audit Manager; Dore C. Tanner, CPA; Edwin Shepherd; and Cora. L. Bryant.

Respectfully submitted,

S. FLOYD MORI
Chairman, Joint Legislative
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SUMMARY

The Department of Social Services (DSS) is responsible for licensing, monitoring and regulating residential care facilities for children. The department is to ensure that facilities providing nonmedical residential care must be adequate, safe, and sanitary and that residents must receive quality care. The DSS contracts with 48 counties which have elected to license and monitor certain community care facilities.

We found that the Department of Social Services has inadequately monitored the standards of care in residential facilities for children. Specifically, the DSS has not ensured that licensed residential care facilities have been fully evaluated. Approximately 50 percent of the facilities licensed by the State have either not been evaluated since they were first licensed or have not been evaluated since January 1, 1979. Also, county agencies have improperly cited facilities for violations of regulations and have failed to conduct unannounced visits to evaluate facilities. The department has not assessed civil penalties against all facilities out of compliance with laws and regulations. Further, the department has not fully documented or promptly conducted all complaint investigations.

To improve the administration of the licensing of residential care facilities for children, we recommend that the Department of Social Services conduct annual evaluations for facilities and ensure that county licensing agencies thoroughly cite facility violations and conduct unannounced visits to facilities. Additionally, we recommend that the department assess civil penalties to motivate facilities to correct deficiencies and require personnel to adequately document and promptly conduct complaint investigations.

In addition to these problems with the administration of residential care facilities, we also noted weaknesses relating to the screening of facility personnel. We found that criminal record reviews have not been performed for more than half of the facility staff requiring such reviews. Further, certain individuals with felony and misdemeanor convictions have been allowed to work in facilities licensed by the State and the county even though they have not been granted exemptions to do so. Because of this inadequate review of personnel, children are exposed to unnecessary risks that may endanger their physical and mental health. We recommend, therefore, that the Department of Social Services comply with existing laws and regulations by conducting criminal record reviews for all personnel who provide service to or who are employed by any residential facility. Additionally, the DSS should grant exemptions for facility personnel determined to be

suitable to care for children or ensure that those facility personnel who are inappropriately qualified are prohibited from working in residential facilities.

Finally, our review disclosed that California does not have an information system that enables placement agencies and concerned citizens to select a community care facility on the basis of quality of care. Such a system is required by the Health and Safety Code; however, the department has not implemented this requirement because of difficulties in constructing a system for rating various levels of facilities. Although we agree that a rating system may be difficult to implement, an information system could provide placement agencies and other concerned parties with inspection reports and complaint data. Therefore, we suggest that the Legislature consider requiring the Department of Social Services to submit plans to implement a comprehensive information system.

INTRODUCTION

In response to a request by the Joint Legislative Audit Committee and under the authority vested in the Auditor General by Section 10527 of the Government Code, we have reviewed the Department of Social Services' administration of the licensing of residential facilities for children, focusing upon the department's monitoring of the quality of care in these facilities.

BACKGROUND

The Community Care Licensing Division of the Department of Social Services (DSS) is responsible for licensing, monitoring, and regulating community care facilities. The division's seven district offices conduct these monitoring and licensing functions. In addition, the DSS contracts with 48 counties that have elected to license and monitor certain community care facilities. These county licensing agencies are required to conform to the rules, regulations, and standards of the DSS as well as to the requirements of the California Community Care Facilities Act.

The California Community Care Facilities Act was enacted to establish a coordinated and comprehensive service system of providing quality nonmedical residential care for

these individuals: socially dependent children (foster children) and adults, the mentally disordered, and the developmentally and physically disabled.* The act further requires that facilities providing community care be adequate, safe, and sanitary and that residents receive quality care. The intent of the community care licensing program is to ensure that all persons are served by licensed community care facilities which meet established health and safety standards.

Licensing Procedures

Community care facilities submit applications for operating licenses to the appropriate state or county licensing agency. Before issuing a license, the licensing agency must review the facility to ensure that it is adequate, safe, and sanitary as required by provisions of the Health and Safety Code. Further, the department must conduct criminal record reviews of facility personnel to determine if they have ever been convicted of a criminal charge. If the facility or its personnel do not meet established criteria, the department shall not issue the license.

* The California Community Care Facilities Act is contained in Section 1500 *et seq*. of the Health and Safety Code.

Once a license has been issued, licensing agencies are required to periodically evaluate all licensed facilities to determine the quality of care provided to residents. If, during these evaluations, the agency notes a deficiency--any failure to comply with laws and regulations--the facility operator must correct it within a specified time. Serious deficiencies, those which could result in an immediate or substantial threat to the health or safety of a facility resident, include violations of regulations pertaining to storage and preparation of food, fire clearance, behavioral restraints, and medical care. When a facility does not correct a deficiency, the department's regulations require the assessment of a civil penalty. In addition, when a facility violates laws and regulations, its license may be suspended or revoked.

There are two general classes of facilities providing residential care for children: family homes and group homes.

- Family homes are licensed to provide 24-hour care and supervision in a family setting for not more than 12 children;

- Group homes are licensed to provide 24-hour care and supervision for children in a group setting.

During fiscal year 1979-1980, approximately 14,400 residential facilities were licensed to care for an estimated 30,000 children in California.

Program Funding

Community care licensing activities are funded entirely from the State's General Fund. The budget for the Community Care Licensing Program for fiscal year 1980-81 is approximately $27.8 million. This amount includes approximately $16 million for county contracts. The 1980-81 allocation to the counties is based upon the number of licenses issued by each county.

The 1980-81 budget is approximately 23 percent greater than the budget for the previous year. This budget increase is partially attributable to an increase of approximately $3 million in county contracts and an augmentation of state staffing. Presently, the division employs about 300 personnel--approximately 200 of these employees work in the district offices.

AUDIT SCOPE AND METHODOLOGY

This report specifically addresses the licensing of residential facilities for children. In conducting our review, we selected a sample of licensing case records for children's

residential facilities at district offices located in Berkeley, Los Angeles, Sacramento, and San Diego. We also reviewed a sample of facilities licensed by welfare departments in these counties: Alameda, Los Angeles, Sacramento, and San Diego. The purpose of these reviews was to determine whether facilities complied with the statutory provisions of the Health and Safety Code and related regulations. We also interviewed department staff and analyzed state and county procedures and policies pertaining to licensing practices.

CHAPTER I

THE DEPARTMENT OF SOCIAL SERVICES HAS INADEQUATELY MONITORED THE QUALITY OF CARE IN RESIDENTIAL FACILITIES FOR CHILDREN

The Department of Social Services has not adequately ensured that children in residential facilities receive the quality of care mandated by laws and regulations. Specifically, we identified three areas in which laws and regulations have not been fully implemented:

- Facilities licensed by the State and the counties have not been adequately evaluated;
- Civil penalties have not been assessed against facilities out of compliance with laws and regulations;
- Complaint investigations have been inadequately documented and untimely.

Unless these deficiencies are corrected, the health and safety of children may be threatened. The remainder of the chapter further describes each of these areas.

FACILITIES HAVE NOT BEEN ADEQUATELY EVALUATED

The Department of Social Services has not ensured that residential care facilities for children have been adequately evaluated. The law requires that these facilities be evaluated every 12 months. At the state level, we found that approximately 50 percent of the facilities licensed for more than 12 months have either never been evaluated since they were first licensed or have not been evaluated since January 1, 1979. Consequently, the department is unaware of the number and types of deficiencies that exist in these facilities. Until these problems are identified, the DSS cannot require appropriate corrective action.

In reviewing four county licensing operations, we found that county agencies are not evaluating facilities in accordance with state law and departmental policy. For example, agencies have not cited the specific regulations violated by facilities. Thus, the State does not have sufficient documentation to suspend or revoke a facility's license. County agencies have also failed to give facilities a written copy of the deficiency notice and to establish a date by which the violation must be corrected. Without this written notification, the facility has no official record requiring it to correct the problem. In addition, county agencies are not conducting unannounced facility visits. By announcing or

scheduling home visits, the evaluator has no assurance that the facility is being observed under normal conditions.

Section 1534 of the Health and Safety Code requires the department to inspect and evaluate community care facilities. To ensure quality care is provided to residents, this section mandates that every facility be inspected and evaluated at least once a year for compliance with laws and regulations.

State Operations

We reviewed a sample of 189 state facilities that have been licensed for more than 12 months. We found that 43 of these facilities or 23 percent of the sample cases had never been evaluated since they were first licensed. An additional 49 facilities--26 percent of the sample cases--had not been evaluated since January 1, 1979.

On the average, each facility received over two deficiencies per annual evaluation. Approximately one serious deficiency was noted for every two facilities evaluated. These deficiencies included noncompliance with staffing regulations and client personal rights as well as violations related to improperly stored medicines and pesticides. Until a facility is evaluated, the department cannot be apprised of the deficiencies that may exist and thus cannot institute corrective action.

We found that the frequency of evaluations corresponded to staffing levels in some district offices. In those offices that had higher staffing levels, we generally found that facilities had been evaluated each year and that more evaluations were being conducted. But within district offices that had experienced staff shortages, we found that facilities had not been promptly evaluated. In fact, many of the facilities had never been evaluated. The department's staff was augmented in fiscal year 1979-80. These positions were filled in April 1980. This increased staffing should result in more timely evaluations.

County Operations

During our review of county licensing agencies, we found that the DSS has not ensured that these agencies have fulfilled their contractual obligations to evaluate community care facilities. County agencies have failed to properly cite deficiencies within facilities. Furthermore, agencies usually notify facilities of evaluation visits rather than conduct unannounced evaluations. In addition, deficiencies are not properly reported and facilities are not required to correct deficiencies.

Failure to Properly Cite Deficiencies

County licensing agencies are required to cite deficiencies when they observe instances of noncompliance with state law and regulations. When the evaluator observes a deficiency, he is required to prepare a deficiency notice. This notice must cite the regulation violated and describe the manner and location in which the facility failed to comply with the established statutes. Further, facilities must receive a written notice of the deficiency and a date by which the deficiency must be corrected.

Our review disclosed that over 75 percent of the evaluation reports for the facilities having deficiencies did not list the specific regulation violated and did not include a description of the violation. For example, one facility was cited for not having a "clean house" rather than being cited for violation of Section 85169(e) of Title 22, California Administrative Code. Further, the citation should have included a factual description that detailed the extent of the violation and the type of uncleanliness noted.

In addition, we found that most county licensing agencies are not notifying facilities of the specific deficiencies in writing and are not indicating the date by which the deficiency must be corrected. Unless the facility

receives such written notification, it is under no obligation to correct the deficiency. Further, specific documentation is required to support a decision to suspend or revoke a facility's license.

Most county agency personnel stated that the DSS has not adequately instructed them in procedures for citing deficiencies. Contracts between the DSS and the counties require that the department assist county staff in training.

Failure to Conduct Unannounced Visits

Department contracts with the counties also require evaluations to be conducted on an unannounced basis so that evaluators can observe facilities under normal conditions. We found, however, that most county licensing agencies are notifying the facilities in advance of the date of the evaluations. Announced visits permit facility operators to prepare for the evaluation; thus, the evaluator may not observe the facility under normal conditions.

Two of the four county licensing officials we contacted stated that they announce the dates when evaluations are conducted because organizations of local foster parents have resisted unannounced evaluations. These county officials also believe that announced visits permit more efficient use of

staff and reduce transportation costs. However, management staff of the department have stated that efficient use of staff and transportation can be accomplished through unannounced evaluations.

Announced visits by county licensing agencies may partially explain the variation between the number of deficiencies cited for county-licensed facilities and those cited for state-licensed facilities. County-licensed facilities receive fewer deficiencies than comparable state-licensed facilities. In reviewing a sample of 306 county-licensed facilities, we found that only 127 deficiencies had been cited for these facilities. On the other hand, the 109 state-licensed facilities in our sample received 213 deficiency citations--nearly twice the citations for one-third as many facilities.

CONCLUSION

The Department of Social Services has not ensured that all residential care facilities for children have been adequately evaluated. Approximately 50 percent of all district facilities that have been licensed for more than 12 months have not been evaluated since they were first licensed or have not been evaluated in over a year. Further, county agencies under the department's direction have failed

to properly cite facility violations and to conduct unannounced evaluations. These inadequate evaluations could fail to disclose facility deficiencies that represent a threat to the health and safety of children. Also, until violations are identified, the department cannot institute corrective action.

RECOMMENDATION

We recommend that the Department of Social Services determine which facilities do not have current annual evaluations and conduct such evaluations as required. We further recommend that the Department of Social Services ensure that county licensing agencies:

- Cite the regulations violated and provide a full description of the deficiency noted;

- Provide facility operators with written notices of deficiencies and indicate the date by which the deficiencies must be corrected;

- Conduct unannounced visits to facilities.

Finally, we recommend that the department ensure that county personnel are adequately trained in conducting facility evaluations.

CIVIL PENALTIES HAVE NOT BEEN ASSESSED AGAINST DEFICIENT FACILITIES

The Department of Social Services is authorized to levy civil penalties not to exceed $50 a day against facilities that fail to comply with laws and regulations. However, the four district offices we visited had assessed only two civil penalties against residential care facilities for children. Further, we found instances in which the department should have assessed civil penalties but failed to do so. These problems result in inconsistent enforcement of laws and regulations; furthermore, when civil penalties are not assessed, facilities have little financial incentive to correct existing deficiencies.

In 1973, the Legislature enacted Section 1534 of the Health and Safety Code. This legislation authorizes the department to levy civil penalties not to exceed $50 a day against facilities that fail to comply with laws and regulations.* Department regulations prescribe assessments of $50 per day for serious deficiencies, and $25 per day for other deficiencies. If the facility corrects the deficiencies within the time period allowed by the department, no civil penalties are assessed; thus, the facility has a financial incentive for

* Foster family homes are exempt from assessment of civil penalties.

implementing corrective action. If the deficiency is not corrected, the daily assessment continues until the facility corrects the deficiency.

In 1979, the department issued regulations to implement the citation system. These regulations require civil penalties to be issued against facilities for failure to correct deficiencies. Citations were not issued from 1973 until the adoption of these regulations in 1979.

Cases Warranting
Civil Penalties

Our review disclosed that since 1973 only two civil penalties have been assessed by the four district offices we reviewed. This figure represents assessments against less than one percent of the residential facilities for children in the districts we reviewed. Additionally, we found four cases in which civil penalties should have been assessed because uncorrected deficiencies existed. In each of these cases, the facilities were given an opportunity to correct the deficiencies; however, the violations were not corrected and no civil penalties were assessed. Failure to assess civil

penalties in these four cases represents inconsistent enforcement of laws and regulations. These are the four violations we found:

- Failure to operate within licensing limitations;
- Failure to maintain first aid supplies;
- Failure to have staff trained in first aid procedures;
- Failure to obtain consent forms to authorize emergency medical care.

The last case listed, failure to obtain consent forms, serves to illustrate that facilities need a financial incentive to correct problems. The facility cited for this serious deficiency was given 14 days to correct it. When the department conducted a follow-up evaluation 30 days after the initial evaluation, the deficiency had not been corrected. Even after a second follow-up evaluation, conducted 36 days after the first follow-up visit, the deficiency was still uncorrected. The facility should have been assessed a penalty of $1,800 for the 36 days. The assessment of this civil penalty may have induced the facility to correct this deficiency which posed a threat to the health and safety of the children. Since the department has not assessed all

appropriate civil penalties for uncorrected deficiencies, facilities have little financial incentive to correct their deficiencies.

CONCLUSION

The Department of Social Services has not assessed civil penalties against facilities that did not correct deficiencies. Unless civil penalties are assessed, the facility has little motivation to correct deficiencies that may threaten the health and safety of children.

RECOMMENDATION

We recommend that the Department of Social Services assess civil penalties to motivate facilities to correct deficiencies.

COMPLAINT INVESTIGATIONS ARE INADEQUATELY DOCUMENTED AND UNTIMELY

Neither the Department of Social Services nor the counties have fullfilled their responsibilities to properly document and promptly conduct complaint investigations. Many complaint files do not indicate if the complaint has been substantiated or if the complainant has been notified of the results of the investigation. Other complaint records do not indicate whether an investigation has been conducted. Additionally, many complaints are not investigated within time limits set by the department. These deficiencies exist because licensing personnel have not observed the department's policies and procedures for conducting complaint investigations. Until a complaint is investigated, the department is unable to determine the validity of the allegations or to institute corrective action.

Section 1538 of the Health and Safety Code requires that when the department receives a reasonable written, signed complaint, it must make a preliminary review and an on-site inspection of the facility within ten days. However, the department's policy is to investigate complaints within ten days, even those that are not written and signed.

Citizen complaints are an important source of information on possible violations by community care facilities. A complaint often may be the first indication to the department that a facility is not complying with laws and regulations. We found the following types of serious allegations made in the complaints we reviewed; these allegations illustrate the importance of prompt complaint investigations:

- Unsafe physical plant conditions;
- Poorly maintained facility;
- No adult supervision of children;
- Lack of proper care.

Until these complaints are investigated, the department cannot determine if they are valid or prescribe actions to correct problems.

State Complaint Investigations

Our review of 105 complaints received by the State disclosed that complaints were not adequately documented and that investigations were not promptly conducted. We noted that 32 complaints or 30 percent of the total reviewed were not properly documented. For example, complaint investigation records did not indicate whether an investigation had been

conducted. Also, records of on-site visits were not available. Other records did not indicate whether the complaint was substantiated or whether the complainant was notified of the results of the investigation. As a result, we were unable to determine if an investigation had been conducted.

Our review further demonstrated that investigations were not promptly conducted. Twenty-one complaints or 20 percent of the complaints in our sample were not investigated within the required ten-day limit. In addition, investigators required from 0 to 28 days following receipt of the complaints to conduct on-site reviews of facilities.

County Complaint Investigations

The department's audit reports of county licensing agencies disclosed inadequacies in complaint investigations similar to those we identified in the State's licensing operations. Records did not always fully document the investigation of complaints. Further, records sometimes did not indicate whether the complainant was notified of the investigation results. In addition, auditors of the DSS noted that one county did not maintain a central log file for complaints. They also found that in another county complaint investigation visits were sometimes announced.

Complaint investigation deficiencies exist because state and county personnel are not observing the department's policies and procedures for processing complaint investigations.

CONCLUSION

Complaints are not properly documented and are sometimes not investigated within the ten-day limit. Until a complaint is investigated, the department is unable to determine the validity of the allegations or to institute corrective action.

RECOMMENDATION

We recommend that the Department of Social Services require its district staff and county personnel to comply with complaint procedures by maintaining adequate records of investigations and by investigating complaints within ten days.

CHAPTER II

THE DEPARTMENT OF SOCIAL SERVICES HAS NOT ENSURED THAT CRIMINAL RECORD REVIEWS OF FACILITY PERSONNEL ARE CONDUCTED

Criminal record reviews have not been adequately conducted for personnel working within residential care facilities. Our review of files for facilities licensed by district offices of the DSS disclosed that criminal record reviews have not been performed for more than half of the facility staff. Further, 20 individuals with criminal convictions are working in these facilities. These individuals have not been granted the department's exemption--the determination that they are of good character. Additionally, the DSS has not adequately monitored county procedures for granting or obtaining exemptions for facility staff having criminal convictions. For example, 34 foster parents with criminal convictions were neither granted exemptions nor removed when they did not meet appropriate qualifications. If unsuitable individuals are allowed to staff residential facilities, children are exposed to risks that endanger their physical and mental health.

Statutes within the Health and Safety Code and the California Administrative Code require the Department of Social Services to conduct criminal record reviews for personnel in

residential care facilities. The Health and Safety Code requires the department to obtain a criminal record from an appropriate law enforcement agency to determine whether the applicant, facility administrator, or any other adult living in the same location has ever been convicted of a crime other than a minor traffic violation. The California Administrative Code further requires that a criminal record review be conducted for such additional persons as required by the appropriate licensing agency. In addition, some district offices require criminal record reviews for any employee who supervises or cares for facility residents. For foster family homes, criminal record reviews are required for any person who is employed by or who regularly assists the applicant in the care of children.

If the criminal record review of an individual discloses a conviction other than a minor traffic violation, the application shall be denied, unless exempted by the department or licensing agency. The Director of the Department of Social Services may exempt any applicant with a criminal conviction if the applicant is believed to be of such "good character to justify issuance of a license" and is deemed suitable to care for children. The department retains the authority to approve or deny exemptions for individuals with felony convictions. The licensing agency can grant exemptions for individuals with misdemeanor convictions. Before granting

exemptions, the licensing agency must review a copy of the person's criminal record report, a copy of the rehabilitation certificate, an explanation of the circumstances, and statements of at least five character references.

State Operations

To determine compliance with the above criteria, we reviewed a sample of facility files at four DSS district offices. We found that criminal record reviews had not been performed for 55 percent of facility personnel requiring such review. Specifically, reviews were not conducted for 68 percent of the staff working in group homes and for 29 percent of the staff in family homes. Table 1 details the results of this sample.

TABLE 1

CRIMINAL RECORD REVIEWS FOR FACILITY PERSONNEL

	Family Homes		Group Homes		Total	
	Number	Percentage	Number	Percentage	Number	Percentage
Reviews not completed	71	29%	319	68%	390	55%
Reviews completed	171	71	150	32	321	45
Individuals requiring reviews	242	100%	469	100%	711	100%

The number and types of convictions for the 390 persons having no criminal record reviews (55 percent of our sample) are unknown.

Additionally, 20 of the 321 individuals whose criminal records had been reviewed were allowed to work in facilities even though they had felony convictions, misdemeanor convictions, or both. The files did not indicate that the district offices had acted to process exemptions for them. The criminal convictions for these 20 facility employees are listed in Table 2.

TABLE 2

CRIMINAL CONVICTIONS FOR TWENTY PERSONNEL IN STATE-LICENSED FACILITIES

Crime	Number of Convictions
Felonies:	
Burglary	6
Grand theft	3
Possession of drugs	1
Receiving stolen property	2
Total Felony Convictions	12
Misdemeanors:	
Assault	1
Resisting arrest	1
Theft	7
Illegal use of narcotics	1
Drunk driving/drunkenness	6
Carrying a deadly weapon	1
Reckless driving	2
Writing checks with insufficient funds	4
Other convictions	13
Total Misdemeanor Convictions	36
Total Convictions	48

The department has not fully implemented criminal record reviews because it lacks complete information on personnel working in residential care facilities. Without a list of facility personnel, the department cannot identify staff members who require criminal record reviews. Facilities are required to submit an organizational chart or personnel list at the time of application. Yet there is no requirement that this information be updated and resubmitted periodically. By consulting current personnel lists, the department could more readily identify those facility personnel needing criminal record reviews.

County Operations

In addition to reviewing state licensing operations, we also reviewed the operations of 4 of the 48 counties which contract with the DSS to license facilities. We found that the county licensing agencies had conducted over 90 percent of the required criminal record reviews. However, our examination of the counties' 570 criminal record reviews disclosed that only two individuals with criminal convictions had been exempted to provide care to foster children. We found that 34 individuals with criminal convictions had not been exempted.

These 34 foster parents had shared a total of 132 convictions--23 felonies and 109 misdemeanors. These felony convictions included such crimes as kidnapping, robbery, and

burglary. Misdemeanor convictions included abandonment and neglect of children, prostitution, and possession of narcotics. Table 3 illustrates the types and the number of convictions for the 34 individuals with criminal records.

TABLE 3

CRIMINAL CONVICTIONS FOR THIRTY-FOUR PERSONNEL AT COUNTY-LICENSED FACILITIES

Crime	Number of Convictions
Felonies:	
Burglary	8
Robbery and attempted robbery	7
Kidnapping	1
Assault with a deadly weapon	2
Grand theft	4
Illegal crossing of national borders	1
Total Felonies	23
Misdemeanors:	
Abandonment and neglect of children	5
Prostitution	4
Possession of narcotics	21
Possession of drugs without prescriptions	6
Driving under the influence	19
Disorderly conduct	15
Petty theft	9
Carrying a concealed weapon	5
Forgery	6
Gambling in the home	5
Assault and battery	1
Operating a vehicle with a suspended license or with no license	6
Other misdemeanors	7
Total Misdemeanors	109
Total Convictions	132

Two foster parents in one home were convicted of 40 of the 132 crimes shown in Table 4. In this extreme case, the foster parents had 4 prostitution, 20 narcotic, and 16 other convictions. The remaining 92 convictions were distributed among the other 32 individuals.

Three of the four county officials we interviewed claimed that they were unaware of the process for granting and obtaining exemptions for personnel convicted of crimes until the State issued guidelines in July of 1979. The other county official claimed that he was not aware of the DSS policy until February 1980. These guidelines allow the counties to grant exemptions for misdemeanor convictions and require that agencies submit applications for the exemptions of felony convictions to the DSS. As stated previously, the department retains the authority to grant these exemptions.

Unless the licensing agencies conduct necessary criminal record reviews, unsuitable individuals may be allowed to care for children. Reviews of criminal records will identify individuals whose criminal convictions cannot be exempted and thus may exclude such persons from employment in residential care facilities.

CONCLUSION

The Department of Social Services has not ensured that criminal record reviews of facility personnel have been conducted. Without these reviews, unqualified or unsuitable persons may be allowed to staff residential care facilities. Thus, the health and safety of children in these facilities may be threatened.

RECOMMENDATION

We recommend that the Department of Social Services

- Require criminal record reviews for all personnel who regularly provide service to or who are employed by a residential facility caring for children;
- Require that each facility serving children annually submit personnel lists so that the department may more readily identify persons requiring criminal record reviews;
- Require evaluators to periodically verify that all required criminal record reviews have been conducted for personnel listed;

- Comply with existing laws and regulations by granting or obtaining exemptions for facility personnel or by ensuring that those facility personnel who are inappropriately qualified are prohibited from working in residential facilities.

Further, the department should ensure that county licensing agencies comply with laws and regulations concerning criminal record reviews.

CORRECTIVE ACTION TAKEN

The department has issued instructions to all district managers to review and update all criminal records during periodic facility evaluations. Additionally, recent staffing increases in April 1980 should result in improved criminal record reviews.

CHAPTER III

OTHER MATTERS FOR CONSIDERATION BY THE LEGISLATURE

A STATEWIDE COMMUNITY CARE FACILITY INFORMATION SYSTEM IS NEEDED

California does not have an information system that enables placement agencies and concerned citizens to select a community care facility on the basis of quality of care. Such a system is required under the provisions of the Health and Safety Code, yet the department has not implemented this requirement. With an adequate information system, placement workers could select a facility which meets the specific needs of the child. This selection could enable the placement worker to place the child in the best available facility.

Each district and county licensing office maintains files on residential facilities. When a facility does not comply with health and safety standards, the state licensing agency generally forwards a copy of the facility inspection report to the placement agency of the county in which the facility is located. State and county agencies informally exchange information concerning the placement of children. However, this information is not summarized and cannot be easily provided to interested placement agencies statewide.

Rating System
Not Implemented

Section 1535 of the Health and Safety Code requires the department to adopt an equitable and uniform method for evaluating the quality of care and services provided by each category of community care facility.* Such ratings are to be published annually, updated quarterly, and distributed to interested parties, such as placement and licensing agencies. Regulations to implement this 1973 law were adopted in January 1976; however, the system has not yet been instituted.

Department management gave several reasons why they have not implemented the rating system. They stated that a rating system, as required by the law, would be difficult to implement because it would require subjective evaluations of facilities and continuous updating of records. Further, the various levels of care possible within a single category of facility further complicate the implementation of such a system. Family homes, for example, include facilities for the mentally and developmentally disabled, the physically handicapped, and wards and dependents of the court. Yet each of these facilities would receive a rating which would be used to compare it to all other facilities in the same category.

* Foster family homes are exempt from rating evaluations.

Need For A Statewide Information System

Although we agree with the department that a rating system may be difficult to implement, an information system with inspection reports and complaint data would allow placement workers to choose the best available facility in which to place a child. Our review of facility inspection reports disclosed that one residential facility had been cited for 28 deficiencies, 9 of which were serious deficiencies. If placement workers received current information about this facility, they could then direct children to other facilities that had received no deficiencies.

Department management agreed that an information system that describes licensed facilities is needed. Department officials added that such an information system would be valuable to the residents, placement agencies, and management staff of the licensing program. Several information systems for nursing homes could be adapted for residential facilities in California. Below, we discuss the systems used in Los Angeles County and in the states of Florida and Texas.

Los Angeles County's Nursing Home Information and Referral Service

Los Angeles County has developed a nursing facility information and referral system. The purpose of this system, which was implemented in September 1976, is to match the needs

of potential patients with available nursing facility services. Approximately 500 referral requests for nursing facilities are made each week. If a facility is charged with serious patient care violations, as defined by state regulations and county criteria, it is given an automatic 30-day do-not-refer status. Thus, patients will not be referred to that facility for 30 days. Facility administrators may appeal the decision that places the facility on do-not-refer status.

Florida's Nursing Home Rating System

Florida devised a system of rating nursing facilities based upon minimum standards; this system includes a detailed listing of the severity of deficiencies within the facilities. Two rating classes were established. An "A" rating is awarded to a nursing home which meets minimum standards, while a "C" rating signifies that the nursing home does not meet all minimum standards. The rating assigned to each facility must be conspicuously posted within that facility. Further, such information must be disseminated to all interested parties.

Texas' Nursing Home Grading System

Texas has established a method for grading skilled nursing facilities, intermediate care facilites, and custodial care homes. The grading method is based upon a system of positive points awarded for selected services and personnel

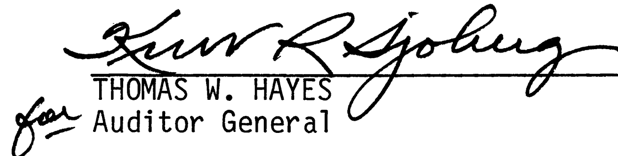
that exceed state-established minimum requirements. Negative points are assessed when selected services, staffing, or operations are not provided in accordance with minimum requirements. To receive a superior grade, a facility must score enough points to attain a net score of 95 or above. For example, a facility with a score of 115 positive points and 20 negative points would earn a net score of 95 and would be awarded a certificate attesting to its superior grade. This grade may subsequently be used in advertising. Further, this information is disseminated to interested parties.

Suggestion for Implementing a Facility Information System

California does not have a statewide information system that enables placement agencies and concerned citizens to select community care facilities based on quality of care. Therefore, we suggest that the Legislature consider requiring the Department of Social Services to submit plans to implement a comprehensive information system. This system should provide

placement agencies and other concerned parties with readily available information to assist in the selection of residential facilities.

Respectfully,



THOMAS W. HAYES
for Auditor General

Date: September 5, 1980

Staff: Robert E. Christophel, Audit Manager
Dore C. Tanner, CPA
Edwin H. Shepherd
Cora L. Bryant

State of California **Health and Welfare Agency**

Memorandum

To : Mr. Thomas W. Hayes
Auditor General
Office of the Auditor General
California Legislature
925 L Street, Suite 750
Sacramento, CA 95814

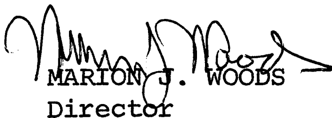
Date : August 29, 1980

Subject : RESPONSE TO AUDIT REPORT

From : **Department of Social Services**

Attached is this Department's response to your audit report, "Improvements Warranted in Licensing of Residential Care Facilities for Children." You will note that our response is divided into three parts; the first responds to those items of the report referring to State district office operations, the second responds to those items referring to the county licensing operations, and the third responds to the need for a statewide information system.

Should you have any questions regarding this response, please contact Anne Bersinger, Deputy Director of the Community Care Licensing Division, at 322-8538.



MARION J. WOODS
Director

Attachment

DEPARTMENT OF SOCIAL SERVICES

RESPONSE TO "IMPROVEMENTS WARRANTED IN LICENSING OF RESIDENTIAL CARE FACILITIES FOR CHILDREN", AUDIT REPORT, OFFICE OF THE AUDITOR GENERAL, CALIFORNIA LEGISLATURE, SEPTEMBER 1980

RESPONSE PART I: STATE DISTRICT OFFICE OPERATIONS

CHAPTER I - THE DEPARTMENT OF SOCIAL SERVICES HAS INADEQUATELY MONITORED THE QUALITY OF CARE IN RESIDENTIAL FACILITIES FOR CHILDREN

A. FACILITIES HAVE NOT BEEN ADEQUATELY EVALUATED

"We found that the frequency of evaluations corresponded to staffing levels in some district offices." (p. 12)

Department Response:

The Department of Social Services (DSS) concurs with the finding that where district office staff shortages have been experienced, all facilities have not been evaluated on a timely basis. To obtain necessary management information, the district offices have reported statistical information commencing in January 1980. For the period January 1980 through May 1980, an average monthly backlog of 400 of the over 2,130 residential facilities for children had overdue annual visits or 18.7% of the total State-licensed residential facilities for children. This period covers the time frame in which the Office of the Auditor General (OAG) conducted its review. DSS believes the approximate 50% of State facilities cited in the OAG report as either not having been evaluated since first licensed or not evaluated since January 1, 1979, may be exaggerated due to the fact that among the district offices selected for review were the offices experiencing the highest staff shortages.

The Department's staffing augmentation in fiscal year 1979-80 included twenty-one (21) licensing evaluator positions which were filled in March and April 1980; an additional seven (7) licensing evaluator positions were approved effective July 1, 1980. The Department concurs that increased staffing should result in more timely evaluations. In fact, statistical data for the months of April and May 1980 reflect a decrease in the percentage of caseload with overdue annual visits.

"Approximately 50 percent of all district facilities that have been licensed for more than 12 months have not been evaluated since they were first licensed or have not been evaluated in over a year." (p. 15)

Department Response:

See Department Response above.

"We recommend that the Department of Social Services determine which facilities do not have current annual evaluations and conduct such evaluations as required." (p. 16)

Department Response:

DSS intensified efforts in January 1980 to identify which facilities were lacking current annual evaluations. The district office managers have been instructed to prioritize workload to ensure that such evaluations are conducted as required. Statewide district office statistics indicate that the percentage of overdue annual evaluations is substantially lower than that cited in the OAG report and decreasing.

B. CIVIL PENALTIES HAVE NOT BEEN ASSESSED AGAINST DEFICIENT FACILITIES

"Our review disclosed that since 1973 only two civil penalties have been assessed by the four district offices we reviewed. This figure represents assessments against less than one percent of the residential facilities for children in the districts we reviewed. Additionally, we found four cases in which civil penalties should have been assessed because uncorrected deficiencies existed." (p. 18)

Department Response:

It should be noted that the regulations to implement the citation system were not promulgated until 1979 by DSS, the successor in July 1978 to the Department of Health as the administering agency of the community care licensing program. Staff training on implementing procedures took place in July 1979.

While the OAG report states that only two civil penalties were assessed by the four district offices reviewed, there is no assessment of the threat of assessed penalties which may have resulted in compliance rather than in assessed penalties. It should be noted as well that over 60% of the State-licensed residential facilities for children by regulation or policy directive were not subject to civil penalties at the time of the OAG review. The report states a finding of only four cases in which civil penalties should have been assessed because uncorrected deficiencies existed. While the number is small, DSS agrees that priority should be given to making use of the civil penalties system to achieve regulatory compliance.

"The facility cited for this serious deficiency was given 14 days to correct it. When the department conducted a follow-up evaluation 30 days after the initial evaluation, the deficiency had not been corrected. Even after a second follow-up evaluation, conducted 36 days after the first follow-up visit, the deficiency was still uncorrected. The facility should have been assessed a penalty of $1,800 for the 36 days." (p. 19)

Department Response:

While there appears to have been a failure to appropriately apply civil penalties in the case cited, it should be noted that regulation requires a follow-up evaluation within ten (10) days following the plan of correction date established in order to assess a civil penalty for a noncorrected deficiency. Failure or inability to follow-up within the ten (10) day period requires a new notice of deficiency, plan of correction and correction date, and subsequent follow-up, again within ten (10) days of the plan of correction date, in order to assess a penalty for the noncorrected deficiency.

"We recommend that the Department of Social Services assess civil penalties to motivate facilities to correct deficiencies." (p. 20)

Department Response:

DSS licensing staff is assessing civil penalties. DSS statistics confirm that all district offices have assessed civil penalties, and penalties have been collected by all but one office. In order to ensure full use of civil penalties in achieving regulatory compliance, district office managers have been instructed to provide any additional training for licensing staff necessary to ensure compliance with established procedure. Civil penalty procedures have also been rewritten and will be included in Evaluator and Clerical Manuals to be issued shortly. At that time, additional statewide training for staff on the application of civil penalties will be conducted.

C. COMPLAINT INVESTIGATIONS ARE INADEQUATELY DOCUMENTED AND UNTIMELY

"Our review further demonstrated that investigations were not promptly conducted. Twenty-one complaints or 20 percent of the complaints in our sample were not investigated within the required ten-day limit. In addition, investigators required from 0 to 28 days following receipt of the complaints to conduct on-site reviews of facilities." (p. 23)

Department Response:

The OAG report does not reflect the time period during which the sample complaints were received. However, Management Information data for the period January 1980 through May 1980 reflect a monthly average of 6.5% of complaints on residential facilities for children being overdue. Again, among the district offices selected for the OAG review were offices experiencing the highest staff shortages; this may account for the higher percentage of overdue complaints found in the OAG review. It is also believed that the recent staffing augmentation has resulted in a decreased number of overdue complaint investigations.

"We recommend that the Department of Social Services require its district staff and county personnel to comply with complaint procedures by maintaining adequate records of investigations and by investigating complaints within ten days." (p. 24)

Department Response:

A directive has been issued to all State licensing staff identifying the investigation of complaints as a number one priority. DSS believes that recent staffing augmentation has also resulted in more timely complaint investigations. Training of State staff is also scheduled on more complete and specific complaint procedures which will emphasize proper documentation and timeliness of complaint investigations.

CHAPTER II - THE DEPARTMENT OF SOCIAL SERVICES HAS NOT ENSURED THAT CRIMINAL RECORD REVIEWS OF FACILITY PERSONNEL ARE CONDUCTED

"We found that criminal record reviews had not been performed for 55 percent of facility personnel requiring such review. Specifically, reviews were not conducted for 68 percent of the staff working in group homes and for 29 percent of the staff in family homes." (p. 27)

"Additionally, 20 of the 321 individuals whose criminal records had been reviewed were allowed to work in facilities even though they had felony convictions, misdemeanor convictions, or both. The files did not indicate that the district offices had acted to process exemptions for them." (p. 28)

Department Response:

It is not clear from the OAG report what criteria were used in establishing which facility personnel required criminal record reviews, particularly personnel in group homes.* Policy established under the Department of Health required criminal record reviews for the applicant, facility administrator, the spouse of the applicant or administrator if residing at the facility, and any personnel left in charge of the facility. Only recently has policy under DSS been issued to licensing agencies to include all personnel supervising or caring for facility residents in group homes. Regulations for foster family homes requiring criminal record reviews for any person regularly assisting the applicant or employed to care for foster children were promulgated in April 1979. Because of the fairly recent nature of these changes, licensing staff are still involved in updating criminal record reviews to conform to regulation and policy changes.

The OAG report assumes that in the absence of evidence in a facility file of criminal record reviews and/or criminal record exemptions that such were not performed. It should be noted that the district offices have received substantial caseloads from agencies which previously performed the licensing function, such as the former Department of Mental Hygiene, and from county licensing agencies. In many instances the transfer of caseload did not include a transfer of criminal record reports. In addition, procedure established under the former Department of Social Welfare which previously licensed much of the current community care facilities workload also mandated the destruction of criminal record reports

* Auditor General Comment: As noted on pages 25 through 27 of our report, we used criteria established by law, regulation and each district office in evaluating the performance of the respective district offices.

which showed no prior convictions. Criminal record reports for personnel previously employed by another facility may not be transferred in all instances to the subsequent facility file but the personnel transfer is noted on a district office master index card for the individual. While the above reflects a problem around documentation that a criminal record review was performed, the absence of a criminal record report in the facility file should not be assumed in all cases to mean that a criminal record review was not performed. DSS has been aware of the absence of documentation as noted above and is working to resolve the problem. In addition, a licensing directive to all licensing agencies will be issued shortly requiring that criminal record reports be transferred with a facility file when licensing responsibility for a facility transfers between agencies.

Current procedures for the processing of exemptions for criminal convictions were issued on October 15, 1979. It is recognized that the documentation of such processing prior to October 15, 1979 may not be present in facility files.

"We recommend that the Department of Social Services

- Require criminal record reviews for all personnel who regularly provide service to or who are employed by a residential facility caring for children;

- Require that each facility serving children annually submit personnel lists so that the department may more readily identify persons requiring criminal record reviews;

- Require evaluators to periodically verify that all required criminal record reviews have been conducted for personnel listed;

- Comply with existing laws and regulations by granting or obtaining exemptions for facility personnel or by ensuring that those facility personnel who are inappropriately qualified are prohibited from working in residential facilities." (pp. 32 and 33)

Department Response:

A licensing directive will be released shortly directing licensing agencies to require criminal record reviews for all personnel who regularly provide service to or who are employed by a residential facility to care for children. The foster family home regulations presently provide for this requirement.

District office managers were directed in April 1980 to review all facility files and update all criminal records. Procedures currently being finalized for the Evaluator Manual, scheduled to be released in October 1980, will require that licensing evaluators either secure from each facility annually a current personnel list or update the personnel list on file. The procedures will also require the evaluators to annually review personnel lists to ensure that criminal record reviews have been or are conducted for facility personnel requiring such reviews. Training for all evaluators will emphasize the need to comply with these procedures as well as procedure covering criminal record exemptions. It is

expected that these steps will ensure that facility care personnel either have no prior criminal convictions (other than minor traffic violations) or are determined to have been rehabilitated.

The DSS will also develop a control system to ensure that all criminal records received which show a prior conviction are reviewed and appropriate action taken. Procedures for clerical maintenance of a control log will be included in the Clerical Manual presently being developed.

RESPONSE PART II: COUNTY LICENSING OPERATIONS

INTRODUCTION

"The 1980-81 allocation to the counties is based upon the number of licenses issued by each county." (p. 7)

Department Response:

The above statement is an oversimplification of the DSS Community Care Licensing (CCL) county allocation formula. A workload standard was used as the basis of the fiscal year allocation. The workload standard methodology divided the average caseload by category, by county, including a trend factor, by the workload standard approved by the Department of Finance. This resulted in person year equivalents (PYE) required to license each category of facility. This PYE times the actual county costs over a twelve month period allocated to that PYE resulted in an initial allocation to which cost-of-living and specific premise items based on mandated regulations or legislation were added resulting in a county allocation.

CHAPTER I - THE DEPARTMENT OF SOCIAL SERVICES HAS INADEQUATELY MONITORED THE QUALITY OF CARE IN RESIDENTIAL FACILITIES FOR CHILDREN

"Further, county agencies under the department's direction have failed to properly cite facility violations and to conduct unannounced evaluations." (pp. 15 and 16)

Department Response:

This conclusion is consistent with some of the findings of DSS county licensing reviews.

"We further recommend that the Department of Social Services ensure that county licensing agencies:

- Cite the regulations violated and provide a full description of the deficiency noted;

- Provide facility operators with written notices of deficiencies and indicate the date by which the deficiencies must be corrected;

- Conduct unannounced visits to facilities.

Finally, we recommend that the department ensure that county personnel are adequately trained in conducting facility evaluations." (p. 16)

Department Response:

In the past two fiscal years DSS staff have reviewed 38 counties representing 95% of the county licensed foster family homes. In those counties where facility violations were not properly cited and/or evaluation visits were announced, deficiencies were cited in the review report. Counties have prepared Plans of Corrective Action (PCA) to address those areas and submitted them for DSS approval. We will continue to monitor county compliance.

It should be noted that prior to the 1980-81 fiscal year counties were not required by contract to use the DSS form, Report of Field Visit. The 1980-81 county contract requires that: "The DSS LIC 809 Form and Procedures (or a similar form and procedure) will be used to document all facility visits."

DSS has conducted county training both on a large scale, regionalized basis on topics requested by the County Welfare Directors Association's Licensing Committee and on an individualized basis. The focus of the Client Protection Services Branch consultants encompasses assisting county staff in the correct implementation of all rules, regulations, policies, procedures and contract requirements. Staff attorneys of the DSS Legal Affairs Division have and are conducting training on the proper completion of a legally correct and defensible LIC 809, Report of Field Visit.

"Complaints are not properly documented and are sometimes not investigated within the ten-day limit." (p. 24)

Department Response:

This conclusion is consistent with some of the findings of DSS county licensing reviews.

"We recommend that the Department of Social Services require its district staff and county personnel to comply with complaint procedures by maintaining adequate records of investigations and by investigating complaints within ten days." (p. 24)

Department Response:

As indicated above, when DSS county reviews identify deficiencies in a county's performance of its licensing responsibilities, it is cited in the subsequent report and the county PCA must address any such deficiency. In addition, the 1980-81 licensing contract obligates the counties to the "Maintenance of a complaint log showing facility name, date of receipt of complaint, nature of complaint, date of site visit, disposition." This is in addition to the normal requirements. DSS will continue its monitoring of county contract compliance.

CHAPTER II - THE DEPARTMENT OF SOCIAL SERVICES HAS NOT ENSURED THAT CRIMINAL RECORD REVIEWS OF FACILITY PERSONNEL ARE CONDUCTED

"The Department of Social Services has not ensured that criminal record reviews of facility personnel have been conducted. Without these reviews, unqualified or unsuitable persons may be allowed to staff residential care facilities. Thus, the health and safety of children in these facilities may be threatened." (p. 32)

Department Response:

This conclusion is consistent with some of the findings of DSS county licensing reviews.

"Further, the department should ensure that county licensing agencies comply with laws and regulations concerning criminal record reviews." (p. 33)

Department Response:

DSS believes county officials should be aware of the process for granting or obtaining exemptions for persons convicted of crimes. All counties were informed by an August 3, 1978 policy letter that all waivers and exceptions were to be forwarded to DSS Community Care Licensing, Policy and Administrative Support Branch (PASB). On July 19, 1979, via a numbered CCL Information Release, #12-79, the authority for waivers and exceptions, except for felony convictions, was delegated to licensing counties for foster family homes. This followed extensive discussions with the County Welfare Directors Association's Licensing Committee. CCL Information Release #15-79 dated October 15, 1979, delegated waiver and exception authority, again except for felony convictions, for the remaining facility licensing categories. Such Releases are sent to all licensing counties, State district offices, and the Department of Education. Both Releases #12-79 and #15-79 make clear that all requests for an exemption for persons convicted of felonies are to be forwarded to PASB for disposition.

As indicated previously, deficiencies in county licensing operations are cited by DSS reviews, and, the county PCA must address any such deficiencies. DSS will monitor counties to ensure they comply with laws and regulations concerning criminal record reviews.

RESPONSE PART III: OTHER MATTERS FOR CONSIDERATION BY THE LEGISLATURE

CHAPTER III - OTHER MATTERS FOR CONSIDERATION BY THE LEGISLATURE

"California does not have a statewide information system that enables placement agencies and concerned citizens to select community care facilities based on quality of care. Therefore, we suggest that the Legislature consider requiring the Department of Social Services to submit plans to implement a comprehensive

information system. This system should provide placement agencies and other concerned parties with readily available information to assist in the selection of residential facilities." (pp. 38 and 39)

Department Response:

DSS agrees with the need to provide potential consumers objective information on a licensed facility. We are continuing efforts towards that end. However, it is not clear from the OAG report whether or not the OAG is aware that in addition to foster family homes, children day care homes and centers are exempted by legislation, Chapter 917, Statutes of 1975 and Chapter 1246, Statutes of 1977, respectively, from the rating requirement.* With all day care facilities and foster family homes exempted, remaining residential facilities for children represent only a small percentage of licensed care in California. The consumers of services for these remaining categories are typically placement agencies which make an independent judgement as to the quality of care provided in a particular facility.

DSS is exploring the listing of the number of civil penalties assessed a facility and also displaying the number of substantiated complaints. Such notations could help the consumer compare the relative merits of facilities providing similar services.

It is also important to realize that the licensing agency could only legally "rate" a facility based on that facility's compliance with California Administrative Code, Title 22, regulations. Title 22 regulations dictate the State's minimum requirements for out-of-home care, in effect, minimum standards. A facility not meeting minimum standards is out of compliance and subject to a deficiency notice and in certain categories civil penalties.

As to the systems listed as adaptable for use by DSS we have requested information from both Texas and Florida. DSS has had many complaints from licensees and licensee organizations regarding Los Angeles County's do-not-refer system. These complaints generally are on the lengthy, well over 30-days, time that it takes to have the do-not-refer status removed after a visit is made, and it is verified that deficiencies are corrected. Given the fact that there are now eight State district offices with two smaller field offices and 48 county licensing agencies, problems of time and distance, that Los Angeles County does not face, could result in even greater unacceptable delays.

* Auditor General Comment: As noted on page 7, our report only addresses residential facilities for children.

cc: Members of the Legislature
Office of the Governor
Office of the Lieutenant Governor
Secretary of State
State Controller
State Treasurer
Legislative Analyst
Director of Finance
Assembly Office of Research
Senate Office of Research
Assembly Majority/Minority Consultants
Senate Majority/Minority Consultants
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