California State Auditor

BUREAU OF STATE AUDITS

Department of Social Services:

Continuing Weaknesses in the Department's Community Care Licensing Programs May Put the Health and Safety of Vulnerable Clients at Risk

August 2003
2002-114

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August 19, 2003 2002-114

The Governor of California
President pro Tempore of the Senate
Speaker of the Assembly
State Capitol
Sacramento, California 95814

Dear Governor and Legislative Leaders:

As requested by the Joint Legislative Audit Committee, the Bureau of State Audits presents its audit report concerning the Department of Social Services (department) and its processes for licensing and monitoring community care facilities throughout California.

This report concludes that state law gives the department wide discretion to decide if people with criminal histories should care for or have contact with community care clients. We found that the department is more selective when granting criminal history exemptions since we issued our August 2000 report, *Department of Social Services: To Ensure Safe, Licensed Child Care Facilities, It Needs to More Diligently Assess Criminal Histories, Monitor Facilities, and Enforce Disciplinary Decisions* (child care report), but it could further improve the thoroughness of its criminal history investigations. Moreover, the department is less timely in communicating final decisions for exemption requests than when we issued the child care report, and its management and investigations of subsequent criminal history reports are inadequate. The department continues to need improvement in how it investigates complaints against community care facilities. Also, licensing offices did not always perform annual on-site facility evaluations as required and thus may be unaware of licensing violations that could pose a danger to children and adults in community care. Although the department adequately monitored the counties with which it contracts to license foster family homes, the department may diminish the effectiveness of its reviews by not consistently making sure those counties correct identified deficiencies. Finally, the department appears to prioritize and quickly process cases involving legal actions against individuals who fail to comply with licensing laws and regulations; however, its enforcement of decisions and orders is not always timely, consistent, or thorough.

Respectfully submitted,

Elaine M. Howle

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State Auditor

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As the State's agency for licensing and monitoring community care facilities, the Department of Social Services:

- ☑ *Has more selectively granted criminal history exemptions since our last review.*
- ☑ *Has been less prompt in communicating exemption decisions.*
- ☑ *Has not adequately managed or investigated subsequent criminal history reports.*
- ☑ *Did not always follow its complaint procedures or make certain that facilities fully corrected identified deficiencies.*
- ☑ *Has adequately reviewed the counties it contracts with to license foster family homes, but has not always corrected identified deficiencies.*
- ☑ *Has prioritized and quickly processed legal actions against facility licensees, but its enforcement of legal decisions was not always timely, consistent, and thorough.*

RESULTS IN BRIEF

The Department of Social Services (department), the agency that licenses and monitors community care facilities in California, must protect community care clients' safety by using diligence and sound judgment in its oversight. State law gives the department wide discretion to decide if people with criminal histories should care for or have contact with clients. We found that the department has been more selective when granting criminal history exemptions since we issued our August 2000 report, *Department of Social Services: To Ensure Safe, Licensed Child Care Facilities, It Needs to More Diligently Assess Criminal Histories, Monitor Facilities, and Enforce Disciplinary Decisions* (child care report).

However, the department could further improve the thoroughness of its criminal history reviews. Moreover, the department has been less prompt in communicating final decisions for exemption requests than it was when we issued the child care report. Although the department's July 2003 emergency regulations will help ensure that individuals with potentially dangerous criminal histories are not present in facilities before it reviews their criminal histories, the department must also be careful not to impede individuals' right to work or facilities' ability to operate by taking an unnecessarily long time to complete its reviews. We also found that the department's management and investigations of subsequent criminal history reports has been inadequate. The background check process is further marred by a gap in its system because the department does not receive information about subsequent criminal activity outside California. Continued weaknesses in the department's process of checking criminal histories may put the safety of vulnerable clients in community care facilities at risk.

The department's investigation of complaints against community care facilities continues to need improvement. For example, licensing offices we reviewed did not always follow procedures when investigating complaints or ensure that facilities fully corrected identified deficiencies. By officially placing annual facility evaluations low on its priority list, the department has chosen to rely on complaint investigations to

identify deficiencies, making adequate investigation of all complaints a crucial part of the department's awareness of licensing violations that could harm clients in community care. We also had concerns with the department's process for licensing facilities because licensing offices did not always consider all necessary information when granting applicants' licenses. Therefore, people unfit to care for vulnerable clients may have obtained licenses. Furthermore, the department did not always perform annual facility evaluations and thus may not have been aware of licensing violations that posed dangers to children and adults in community care facilities.

Although the department reviewed the counties it contracts with to license foster family homes, the department may diminish the effectiveness of its reviews by not consistently making sure those counties promptly correct identified deficiencies. Further, the department lacked procedures to review and assess the counties' reports on criminal history exemptions; therefore, the department has reduced assurance that foster children in the contract counties are entrusted to suitable caregivers. Nevertheless, the counties we visited, Fresno and Kern, adequately carried out their licensing and evaluation functions for the facilities we reviewed, although Kern County did not always follow up to ensure foster family homes corrected their deficiencies. Also, when investigating complaints, both counties sometimes left out important procedures, such as discussing with the department's legal staff allegations of abuse that the county cannot validate.

Finally, although the department prioritized and quickly processed cases we reviewed involving legal actions against individuals who failed to comply with licensing laws and regulations, its enforcement of decisions and orders was not always timely, consistent, and thorough. Legal action helps ensure that anyone who will not or cannot comply with licensing laws and regulations does not care for or come in contact with clients in community care facilities.

RECOMMENDATIONS

To ensure that criminal history exemptions are not granted to individuals who may pose a threat to the health and safety of clients in community care facilities, the department should:

- Make certain it has clear policies and procedures for granting criminal history exemptions.

- Ensure staff are trained on the types of information they should obtain and review when considering a criminal history exemption, such as clarifying self-disclosed crimes and vague character references.

- Review its character reference form to be certain the form's instructions are fully consistent with criminal history exemption guidelines.

To process criminal history reviews as quickly as possible so that delays do not impede individuals' right to work or its licensed facilities' ability to operate efficiently, the department should work to make certain that staff meet established time frames for notifying individuals that they must request a criminal history exemption and for making exemption decisions as requested.

To ensure the department can account for all subsequent criminal history reports it receives and that it processes this information promptly, the department should develop and implement a policy for recording a subsequent criminal history report's receipt and train staff on this policy. In addition, upon receiving a subsequent criminal history report with a conviction, the department should ensure that staff meet established time frames for notifying individuals that they need an exemption.

To ensure that complaints are promptly and thoroughly investigated and that facilities correct deficiencies, the department should do the following:

- Continue to emphasize complaint investigations over other duties.

- Require analysts to begin investigations within 10 days of receiving complaints and, whenever possible, to resolve investigations within 90 days.

- Ensure that analysts follow policies requiring them to refer to the investigations unit any serious allegation within eight hours of receipt and to issue citations for serious allegations the investigations unit has substantiated within 10 days of receipt.

- Make sure that abuse allegations that are deemed inconclusive are reviewed with the legal division.

- Require supervisors to review evidence that facilities took corrective action before signing off on a complaint.

To ensure that it issues licenses only to qualified individuals, the department should collect and consider all required information before it grants applicants' licenses, including, but not limited to, health screening reports, administrators' certifications, and necessary background checks.

If the department plans to continue to defer required facility evaluations, it should do the following:

- Seek legislative approval for its deferral plans.
- Ensure staff understand the guidance on visits that qualify for deferral and that they are properly implementing the deferral policy.
- Modify its licensing information system so that when it defers a visit to a child care home, the visit would be deferred for one year—similar to other facility types—as compared to a full three years.

To help ensure that counties contracting with the department to license and monitor foster family homes adequately and promptly respond to complaints and enforce corrective actions, the department should establish a reasonable time frame for liaisons to prepare reports resulting from reviews of the counties and to notify counties of the results of those reviews. It should also establish a reasonable time frame in which all counties must submit and complete their corrective action plans. Finally, the department should create a reliable method for tracking county corrective actions to ensure they are not overlooked.

To help ensure that counties contracting with the department to license foster family homes are making reasonable decisions regarding criminal history exemptions, the department should develop procedures to ensure that it promptly and consistently reviews quarterly reports on exemptions granted by each contracted county.

To be certain they adequately investigate all complaints against foster family homes and ensure that deficiencies are corrected, the counties should follow current policy and any policy changes the department implements as a result of the recommendations in this report.

The department should conduct follow-up visits to ensure that enforcement actions against facilities are carried out. The department should also document its follow-up for enforcement of revocation and exclusion cases.

AGENCY COMMENTS

Overall, the department concurred with the recommendations in this report and outlined some steps it has already begun to take to implement our recommendations, as well as additional steps it plans to take in the future. In addition, the Office of the Attorney General concurred with the recommendations we made for improving Justice's processes related to the department's licensing programs. Fresno County and Kern County described several ways they will address the issues we raised in the audit report; however, Kern County said that it did not necessarily agree with the audit findings in their totality. ■

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INTRODUCTION

Community Care Programs and Examples of Facility Types

Foster care: 24-hour, live-in care for children who have been removed from their homes, typically because of neglect or abuse. Types of facilities:

Group home: facility of any capacity providing care and supervision, including limited medical services, to children in a structured environment.

Foster family home: provides care in the licensee's family residence for six or fewer children.

Foster family agency: private, nonprofit organization that reviews and approves certified family homes for foster care placement.

Certified family home: similar to a foster family home except that it is certified by a foster family agency rather than licensed by the department.

Senior care: care for individuals 60 years or older who need assistance with daily activities. Type of facility:

Residential care facility for the elderly: provides care, supervision, and assistance with activities of daily living, and may provide incidental medical services under special care plans.

Adult care: 24-hour live-in or day care facilities of any capacity for individuals over the age of 18. Types of facilities:

Adult day care facility: provides nonmedical care for frail elderly and developmentally disabled and/or mentally disabled adults in a day care setting.

Adult residential facility: provides 24-hour nonmedical care for adults aged 18 through 59 who are unable to provide for their own daily needs.

Child care: temporary care and supervision for children.

BACKGROUND

The Department of Social Services (department), through its Community Care Licensing Division (licensing division), is responsible for regulating and protecting the health and safety of children, adults, and seniors in out-of-home care. Specifically, the department licenses and monitors child, adult, and senior care facilities as well as nonmedical residential facilities for children, adults, and seniors.

To provide the necessary licensing services and perform effective monitoring across the State, the department's licensing division is divided along program lines: foster care, senior care, adult care, and child care. Each program has multiple offices located across the State. Table 1 on the following page shows that the State licenses facilities providing care to more than 63,000 foster children, 150,000 seniors, 76,000 adults, and 1.1 million children.

THE DEPARTMENT'S LICENSING PROCESS

The department, through its various licensing offices, uses a formal screening process to license community care facilities. Regardless of the clients the facility is targeted to serve, the licensing process begins with an orientation for potential facility license holders (licensees), which outlines the licensee's roles and responsibilities and how to complete the license application. The process also entails a mandatory criminal history check of the applicant, conducted by the department's Caregiver Background Check Bureau; a review of the applicant's qualifications; and a physical inspection of the proposed facility. Once the department issues a facility license, it is valid until, among other events, the licensee closes or moves the facility or the department takes action to suspend or revoke the license.

TABLE 1

Extent of Care the Department Oversees

Program	Facility Type	Number of Facilities	Clients in Care
Foster Care			
	Group homes	1,691	16,746
	Foster family homes	12,038	30,827
	Foster family agencies	463	13,791
	Other	537	2,564
Senior Care			
	Residential care for the elderly	6,358	150,454
Adult Care			
	Adult day care	733	35,749
	Adult residential care	4,851	39,715
	Other	99	1,337
Child Care			
	Child care homes and centers	56,879	966,439
	Other	4,729	196,581

Source: Department of Social Services.

Note: Foster care program data are current as of March 2003, senior and adult care program data are current as of May 2003, and child care program data are current as of June 2003.

CRIMINAL HISTORY CHECKS

A critical element of the department's licensing process is the criminal history check. By law, all licensees must submit to criminal history checks and cannot be licensed until the check is complete. Individuals such as a licensee's spouse and adult children who will be living in a facility are also required to have criminal history checks. As a facility hires employees, they too are subject to criminal history checks. The department uses criminal history checks to determine if individuals should be allowed to care for or be in close proximity to the facility's clients. The criminal history check includes a review of Department of Justice (Justice) records, which detail arrests for certain crimes and convictions in California, and a search of Federal Bureau of Investigation records.

The criminal history check process begins when an individual submits a set of fingerprints to Justice. Justice processes the fingerprints and notifies the department that there is no history of arrests and/or convictions in California, or sends the department a criminal record transcript (rap sheet). As of September 1999, based on a court ruling stemming from *Central Valley v. Younger* concerning individual privacy, Justice can only disclose convictions and certain statutorily defined serious arrests. Before the court order, Justice issued rap sheets listing all known arrests, whether or not a corresponding disposition was available, and regardless of the disposition type.

THE GOVERNOR'S MORATORIUM ON PROCESSING CHILD CARE CRIMINAL HISTORY EXEMPTION REQUESTS

On March 21, 2002, the governor ordered the department to suspend processing any new criminal history exemption requests related to child care facilities. The governor cited investigations in Orange County that brought to light serious weaknesses in the department's processes as his reason for the suspension. The governor further directed the department to conduct an immediate and comprehensive review of its child care background check process and adopt emergency regulations to require child care providers to inform parents if their facility employs workers with criminal exemptions. In addition, the governor stated he was suspending the department's processing of child care criminal history exemption requests for six months. On July 11, 2003, the department reported the end of the moratorium and stated it had instituted a revised process to review and approve criminal record exemptions for child care facilities.

EXEMPTIONS FOR LESSER CRIMES

To safeguard clients' health and safety, state law prohibits anyone with a criminal conviction from caring for or living with clients in a community care facility. Although the law gives the department authority to grant individuals exemptions to this prohibition as it sees fit, the department cannot grant an exemption to anyone who has committed a crime listed in the statute, such as kidnap or rape. On receiving an individual's rap sheet, the department usually must promptly notify the potential licensee, the facility's owner or operator (in the case of a new employee), or the individual personally that a criminal history exemption is needed. In the case of a new employee for the period we audited, the department also had to decide if the

criminal history was such that the individual should be kept out of the facility until the department made its exemption decision. If the department determined that the new employee's criminal history did not pose a risk to the safety of the clients, the individual was allowed to work at the facility while the department processed the exemption request. Otherwise, the new employee could not work unless and until the department reviewed his or her criminal history and granted an exemption.[1] In contrast, as noted earlier, an individual with a criminal history cannot receive a license to own or operate a facility until the department grants an exemption.

When reviewing an exemption request, the department considers information such as the nature and number of convictions the individual has, the length of time between the conviction and the exemption request, and signs of rehabilitation and remorse. Using this information, the department assesses whether the individual poses a risk to clients. If it perceives no risk, the department grants the exemption. In addition, when a criminal record indicates an arrest with no disposition, such as a conviction, the department has the authority to investigate the events surrounding the arrest. If the department can prove through an arrest record or other obtainable information that an individual poses a threat to the client's safety, it can deny an exemption. Further, Justice sends for the department's review subsequent rap sheets on caregivers and nonclient facility residents who have been arrested after the department's initial criminal history review.

THE DEPARTMENT'S COMPLIANCE VISITS

After issuing a facility license, the department conducts several kinds of visits and evaluations to ensure that the facility is complying with established licensing laws and regulations. For example, state law requires the department to evaluate each facility annually, except child care homes, which the department must evaluate every three years. The department's licensing analysts (analysts) visit all facilities to determine whether they are complying with licensing laws, and when necessary, the analysts give verbal or written consultations, issue citations, and assess penalties.

[1] On July 16, 2003, the department's emergency regulations took effect and significantly changed the department's criminal history exemption process. We discuss the changes more fully in Chapter 1.

The department also performs several other types of visits and evaluations—including prelicensing evaluations, case management visits, and complaint visits—to ensure that each licensed facility is operating in a safe and healthful manner. The department makes complaint visits in response to allegations by guardians or others that a licensee, employee, or nonclient resident is violating licensing laws or regulations. The department is required to visit the facility within 10 calendar days of receiving the complaint. If it substantiates the complaint, the department works with the licensee to prepare a plan to correct the deficiency. The department is then required to follow up to make certain that the licensee has made the necessary corrections. Allegations of serious physical and sexual abuse are generally investigated by specially trained staff currently working in the department's Background Information and Investigation Branch.

THE DEPARTMENT'S LEGAL DISCIPLINE PROCESS

The department has a system of progressive disciplinary actions against any facility licensee, employee, or adult nonclient resident who demonstrates unwillingness to comply with licensing laws and regulations. After a serious or repeated offense, the department can take legal action in the form of a probation term, exclusion from working at any community care facility, and license revocation. The department's legal division must first file an accusation against the individual who allegedly committed a violation. That person has two options: either request a judge, an impartial third party, to hear the case in a formal trial-like setting and render a decision, or allow the department to impose disciplinary actions by default. However the decision is made, it is binding on the individual, and the appropriate licensing office is responsible for enforcing it.

WORKING ENVIRONMENT IN THE DEPARTMENT

The department's staff fulfill their responsibilities in a very difficult environment, one in which they must exercise careful judgment to strike a fine balance between the needs of the vulnerable clients the programs serve and the needs of the licensees who provide services. On the one hand, the clients are the young, the aged, and the disabled who often cannot effectively speak for themselves or act independently. On the other hand, licensees must satisfy the needs of demanding client populations while surviving financially. Thus, the statutes and department regulations and enforcement cannot be so onerous as to cause essential licensees to stop operating.

The laws governing the programs are also very complex, requiring department staff to have a solid command of regulations governing everything from the clients' physical environment (for example, knowing what constitutes a nutritious meal or an unsafe physical plant) to criminal investigations (knowing what evidence is sufficient to demonstrate physical abuse or when a licensee's behavior is so egregious as to require license revocation, for example). Department staff must be alert for violations of any laws or regulations.

Moreover, department staff must make decisions regarding a wide range of complaints, from the seemingly petty that may be symptomatic of more serious problems (for example, deciding if the personal rights of two elderly clients are violated when they are not allowed to sit together for bingo games) to the potentially life-threatening (deciding if clients are being physically or sexually abused, for example). Department staff often must make decisions based on limited information—sometimes comprising only the conflicting testimony of witnesses to events under scrutiny—and within statutory or regulatory time frames.

COUNTY-LICENSED FOSTER FAMILY HOMES

Although the State licenses the majority of foster care facilities, the law gives the department the option of contracting with counties to license foster family homes within their boundaries. Currently, 42 counties in California have contracted with the department. Table 2 lists the contracted counties and the number of licensed foster family homes in each as of February 2003. The department licenses all other types of foster care facilities. Although their licensing authority is limited to foster family homes, the counties, like the department, are responsible for issuing licenses and ensuring that the facilities comply with applicable laws and regulations. In meeting these responsibilities, the counties, like the department, must follow state law and the department's evaluator manual—which contains the policies and procedures department staff follow to license and monitor facilities. When necessary, the counties provide evidence in support of the department's legal discipline process to set probation terms, exclude an individual from working at a foster family home, and revoke licenses. When a decision is final, the county is then responsible for enforcing these decisions.

TABLE 2

County-Licensed Foster Family Homes as of February 2003

County	Number of Licensed Foster Family Homes	County	Number of Licensed Foster Family Homes
1. Alameda	308	22. San Bernardino	600
2. Butte	60	23. San Diego	1,714
3. Contra Costa	423	24. San Francisco	151
4. Del Norte	43	25. San Joaquin	196
5. El Dorado	67	26. San Luis Obispo	90
6. Fresno	309	27. San Mateo	118
7. Glenn	13	28. Santa Barbara	142
8. Imperial	77	29. Santa Clara	480
9. Inyo	12	30. Santa Cruz	101
10. Kern	403	31. Shasta	161
11. Kings	49	32. Solano	130
12. Marin	70	33. Sonoma	163
13. Mariposa	20	34. Stanislaus	131
14. Mendocino	84	35. Sutter	26
15. Merced	66	36. Tehama	45
16. Monterey	105	37. Trinity	20
17. Napa	73	38. Tulare	240
18. Orange	596	39. Tuolumne	35
19. Placer	107	40. Ventura	171
20. Sacramento	424	41. Yolo	51
21. San Benito	10	42. Yuba	26

Source: Department of Social Services.

Note: Total number of county-licensed foster family homes statewide: 8,110.

THE DEPARTMENT'S CHILD CARE PROGRAM

In August 2000, we issued a report titled *Department of Social Services: To Ensure Safe, Licensed Child Care Facilities, It Needs to More Diligently Assess Criminal Histories, Monitor Facilities, and Enforce Disciplinary Decisions* (child care report.) Because the subject matter of the child care report closely parallels that of this report, we frequently compare current and prior audit results, and in Appendix A we outline the department's progress in implementing recommendations we made in the August 2000 audit. Prior audit results are always identified by reference to the "child care report."

Whereas the child care report looked only at the department's licensing and monitoring of child care facilities, this report broadens the focus to include the department's licensing and monitoring of adult care, foster care, and senior care facilities and follows up on recommendations we made for the child care program. The department uses the same basic licensing, monitoring, and legal procedures for all its programs; thus many of the recommendations we made in the child care report also apply to the adult care, foster care, and senior care programs reviewed in the current report. We therefore began this audit expecting to see that the department had implemented our earlier recommendations. In the child care report, we concluded that state law gives the department wide discretion to decide if people with criminal histories should care for or have contact with children. Based on our review at that time, we recommended in the child care report that the department take the following actions:

- Exercise greater caution when using its discretion to grant criminal history exemptions.
- Improve its monitoring of child care facilities after licensure.
- Process its legal cases against caregivers and adult nonclient residents more quickly and provide its staff with clear policies on enforcing all legal decisions.

We also made a recommendation to Justice for improving its criminal history reporting process. Appendix A summarizes the recommendations we made in the child care audit, the department's and Justice's responses, and our follow-up on the department's and Justice's progress in implementing our recommendations.

SCOPE AND METHODOLOGY

The Joint Legislative Audit Committee (audit committee) requested the Bureau of State Audits to assess the department's policies and practices for licensing and monitoring community care facilities, which include foster, senior, adult, and child care facilities. Included in our study are facility licensees, employees, and adult nonclient residents with criminal histories to whom the department has granted exemptions. We also reviewed the operations of selected state-contracted counties that license foster family homes and how the department ensures that the counties license and monitor those homes in accordance with state laws and regulations.

To understand the department's licensing process, we reviewed the relevant laws and regulations and the department's policies for licensing community care facilities. At three licensing offices—Sacramento, Monterey Park, and Fresno—we reviewed the department's methods for ensuring that individuals meet the requirements for operating community care facilities prior to licensure. We similarly assessed Fresno and Kern counties' compliance with these requirements when they licensed foster family homes.

We examined selected criminal history exemption requests the department and the counties processed to determine if they were handled in compliance with statutory, regulatory, and policy requirements. Specifically, we assessed whether the cases met the department's screening criteria, whether the department and counties' decisions were reasonable, and whether the department's cases were processed promptly. We also reviewed Justice's process for distributing criminal history information when the department is assessing an individual's background because the individual committed crimes subsequent to the department's initial review.

To determine whether the department and counties effectively monitor individuals once they are licensed, we reviewed their processes for investigating and following up on complaints against licensees and others. We also reviewed the department and counties' processes of conducting required facility evaluations. Further, we reviewed the department's processes for overseeing counties in their licensing and monitoring of foster family homes in accordance with state law and the department's policies and procedures.

To assess the department's disciplinary process, we reviewed applicable state laws and other relevant materials. We reviewed legal action cases to determine whether the department processes these cases promptly, in accordance with both legal and internal policy requirements. Reviewing legal cases also allowed us to analyze the steps the department took to enforce its legal action decisions, how prompt the department was in taking these steps, and whether the steps were sufficient to ensure that the individual complied with the decision. Although we reviewed exclusion actions for certain facility types, we did not test legal cases excluding individuals from foster family homes because, ordinarily, the department refrains from ordering a spouse or child from their home.

In addition, we evaluated the department and Justice's corrective actions from the child care audit. The department had indicated that many of the recommendations we made in our previous audit could benefit more than just the child care program and that it had implemented corrective actions across its licensing division. To the extent possible, we took steps similar to those we took during the child care audit to determine if the department had in fact implemented our recommendations in all its programs and followed up on those corrective actions that were specific to the child care program. We relied on the results of testing the three other programs to draw conclusions about the department's general responsiveness to our recommendations that the department claimed spanned all programs.

Lastly, the audit committee requested that we compile statistical data on the department's community care facility licensing activity. To accomplish this task, we requested and received from the department the licensing statistics presented in Appendix B. Also included in Appendix B are the number of individuals who needed criminal history exemptions and the number of exemptions that the department granted and denied related to the applications it received in 2002. As requested, we present the number of individuals against whom the department took legal actions, such as placing the person's facility on probation, directing a temporary suspension order, or revoking a facility's license. Finally, along with the department's licensing statistics, we included foster care data the 42 state-contracted counties periodically report to the department. ■

CHAPTER 1

To Ensure the Protection of Vulnerable Clients in Community Care Facilities, the Department of Social Services Should Further Improve Its Process of Reviewing Criminal Histories

CHAPTER SUMMARY

To protect clients' health and safety, the law prohibits anyone with a past criminal conviction from owning, operating, working in, or living in a licensed community care facility. However, the law allows the Department of Social Services (department) to grant individuals exemptions to this requirement, except people convicted of specified serious crimes, and the department exercises wide discretion in carrying out this task. We found that the department was more selective when granting criminal history exemptions since we issued our August 2000 report, *Department of Social Services: To Ensure Safe, Licensed Child Care Facilities, It Needs to More Diligently Assess Criminal Histories, Monitor Facilities, and Enforce Disciplinary Decisions* (child care report). The law and the department's policies and procedures for conducting criminal background checks are substantially the same for child care facilities as for the other facility types we examined for our current audit: foster care, adult care, and senior care. Nonetheless, the department's process of reviewing criminal histories does not yet fully protect the vulnerable populations in community care facilities.

Several weaknesses in the department's process of checking criminal histories persist and may put the safety of clients in community care facilities at risk. In our current examination of 45 exemptions the department granted, we concluded the department could further improve the thoroughness of its criminal history reviews. Moreover, the department's timeliness in notifying applicants who require exemptions and in communicating its final decisions for exemption requests worsened since we issued the child care report. Although the department's July 2003 emergency regulations will help ensure that individuals with potentially dangerous criminal histories are not present in facilities before it reviews their criminal histories, the department must also be careful not to impede

individuals' right to work or facilities' ability to operate by taking an unnecessarily long time to complete its reviews. Also, when the department determined it needed to investigate arrest-only information, which discloses arrests for crimes without convictions, it failed to effectively track cases to their conclusion, and at times the department used its discretion to issue criminal history clearances to individuals whose criminal history information indicated they were actively involved in court-mandated diversion programs. As such, the department violated its own policy of seeking additional information to determine whether the court's requirements were satisfactorily met. Significant problems also exist in the way the department processes and makes decisions regarding subsequent criminal history information it receives from the Department of Justice (Justice), although it appears that Justice has improved its systems and is able to send subsequent criminal histories to the department in a timely manner. The background check process is further marred by a potential gap because the department does not receive information about subsequent criminal activity outside California. Because of these continuing weaknesses in the department's process of checking criminal histories, the risk is greater that vulnerable clients in community care could be living in unsafe facilities.

THE DEPARTMENT HAS SIGNIFICANT DISCRETION WHEN GRANTING CRIMINAL HISTORY EXEMPTIONS

Although state law prohibits anyone with a past criminal conviction from providing care or residing in a licensed care facility,[2] the law also gives the department broad authority to grant exemptions to this rule. To fulfill the law, the department has a specialized unit that handles its criminal history exemption function: the Caregiver Background Check Bureau (CBCB). By granting a criminal history exemption, the CBCB is acknowledging that the convicted individual has demonstrated he or she is of sufficiently good character and should be allowed to own, operate, work in, or reside as an adult nonclient in a community care facility. In addition to gathering statements from the convicted individual, the CBCB gets criminal record transcripts (rap sheets) from Justice for this purpose.

[2] The prohibition does not apply to minor traffic violations.

State law prohibits the department from exempting individuals convicted of certain crimes, including the following:

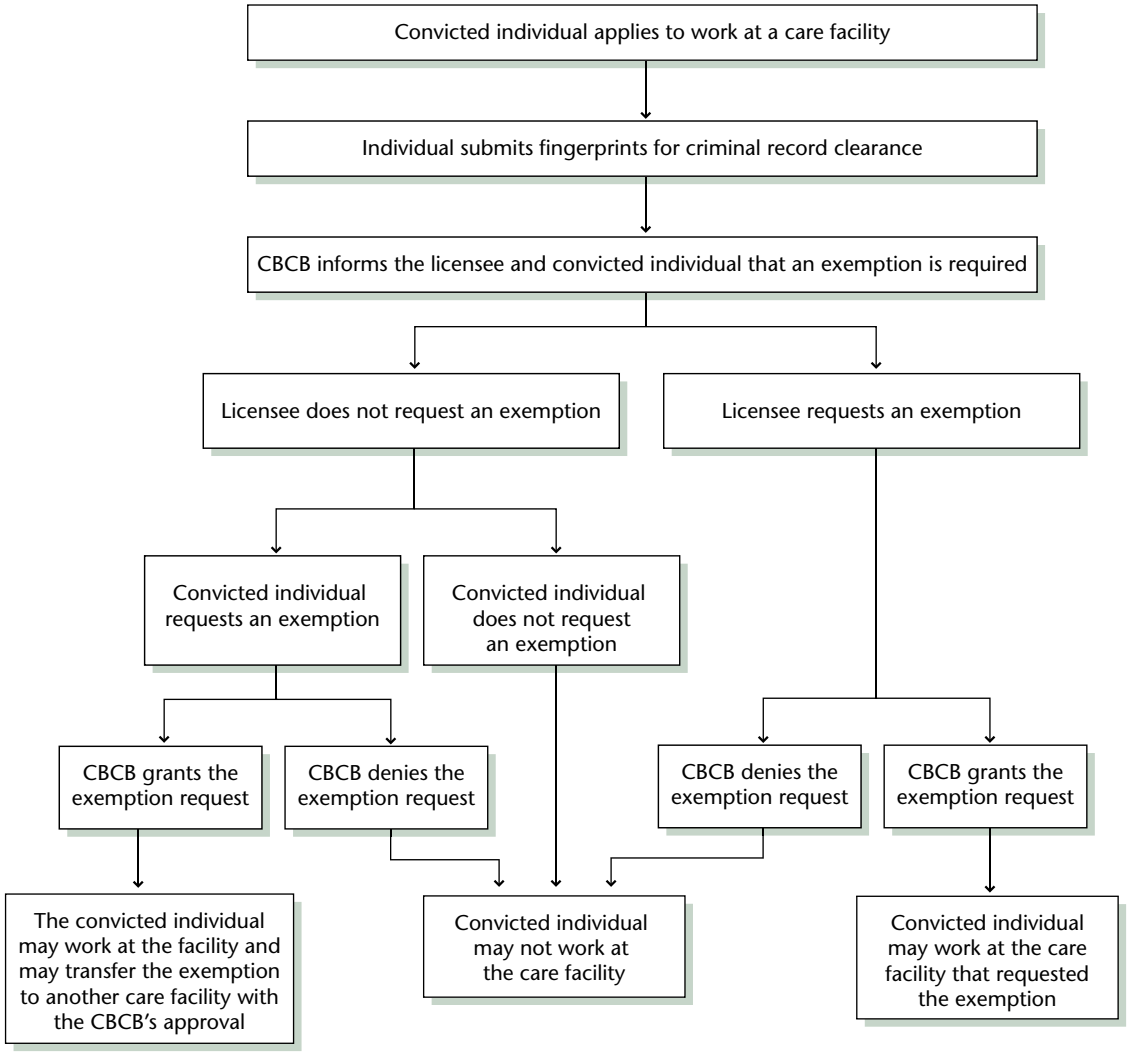
- Rape
- Kidnapping
- Torture
- Robbery
- Arson
- Carjacking

The existence of this assessment process may have led to a perception gap: Clients' relatives and the public may believe that most applicants with criminal histories are not allowed to be caregivers—whereas in reality the department can and does allow convicted criminals to own and work in licensed care facilities if the individual has been rehabilitated and meets other requirements. State law expressly prohibits the department from exempting people convicted of such crimes as rape or kidnapping; however, it allows the department to consider for exemption individuals who have committed other crimes, even felonies such as assault with a deadly weapon. The law further prohibits the department from granting a criminal history exemption to anyone who has been convicted of murder or certain other violent felonies and seeks to own, operate, work in, or reside as a nonclient adult in a child care, senior care, or adult care facility. However, the law allows the department to consider granting criminal history exemptions to prospective foster care facility caregivers convicted of murder and certain other violent felonies. To be considered for such an exemption, an individual must demonstrate rehabilitation for at least 10 years and obtain either a recommendation from the district attorney in the county where the individual lives or a certificate of rehabilitation from a trial court. The Legislature is currently considering legislation that would eliminate the department's ability to grant exemptions for murder.

As Figure 1 on the following page shows, the owner or operator of the community care facility must decide whether to seek a criminal history exemption for a convicted individual who wants to work or live at the facility. If the owner or operator does not request an exemption, the individual cannot work or reside there, but can request an exemption from the CBCB on his or her own behalf (individual exemption request). Whether the owner, operator, or the individual requests the exemption, the individual must support the application by providing a statement detailing his or her version of the events surrounding the conviction(s), what happened and why, and a description of what he or she has done to prevent a recurrence of criminal behavior.

FIGURE 1

Criminal History Exemption Process



The CBCB was more selective when granting criminal history exemptions than it was during the period we reviewed for our child care report. In fact, in our current testing of 45 criminal history exemption approvals, we found the CBCB granted exemptions for six individuals with felonies, compared to 10 individuals with felonies of 25 approvals we examined for our child care report. Furthermore, of the six individuals with felonies the CBCB granted exemptions, at least 14 years had elapsed since the individual's most recent arrest. In contrast, for seven of the 10 felony approvals we examined for our child care report, fewer than 10 years had elapsed since the individual's most recent arrest.

THE CAREGIVER BACKGROUND CHECK BUREAU GRANTED EXEMPTIONS WITHOUT CONSIDERING ALL AVAILABLE INFORMATION

Despite its greater selectivity when granting exemptions, the CBCB still did not sufficiently consider information other than convictions when reviewing five of the 45 approvals we examined. The department's evaluator manual—which contains departmental policies and procedures—says that a decision to approve or deny an exemption must be based on a comprehensive review of all available information. The manual instructs the CBCB staff to consider factors such as the age of the crime, a pattern of activity potentially harmful to clients, and compelling evidence to demonstrate rehabilitation. However, the CBCB did not always consider all these factors.

The Caregiver Background Check Bureau did not always consider self-disclosed crimes when granting criminal history exemptions.

In three of these five cases of approved exemption requests, the CBCB ignored self-disclosed crimes not appearing on individuals' rap sheets. For example, the CBCB granted an exemption to an individual who had met the minimum waiting period past his probation for a conviction of a misdemeanor battery incident that took place when he was drunk. However, the man disclosed in his statement accompanying the exemption request that he had a subsequent drunken driving conviction. Moreover, the analyst reviewing the exemption request (exemption analyst) was aware of the drunken driving conviction the man had disclosed yet failed to obtain any information explaining the crime's circumstances prior to recommending approval. The manager overseeing the exemption process (exemption manager) agreed that this exemption decision was questionable, considering the information the exemption analyst had at the time. In two other cases when the CBCB requested criminal history exemptions for past convictions, a man and a woman both disclosed past arrests. The man disclosed he was arrested for assaulting a police officer, and the woman disclosed she had a recent charge of cruelty to an animal, a potential violent misdemeanor. In both instances, the CBCB granted criminal history exemptions without obtaining arrest reports or determining if the arrests resulted in convictions. By not considering all information available, the CBCB may overlook important patterns or events that are detrimental to the safety of clients in care facilities.

For the remaining two instances where the CBCB granted exemptions without considering all available information, the CBCB accepted without question character references that appeared inadequate. To obtain an exemption, an applicant with a criminal history must have three people submit character

references, which the CBCB uses to help evaluate the applicant's fitness to be a caregiver or a nonclient resident. The CBCB informed applicants that references cannot be from relatives or licensed facility employees, but the CBCB did not specify what information the reference letter should contain. Department policy directs exemption analysts to consider whether the letter indicates the reference knows of the criminal record and still thinks the individual is acceptable. One applicant appeared to have written one of her own references, because the handwriting was conspicuously similar to other written information the applicant had provided. The CBCB accepted two references for another applicant that had been written by facility employees, which the department's policy specifically prohibits. In addition, the man we described previously who disclosed a drunken driving conviction provided the CBCB with cryptic, almost identical letters. Each of the three typed letters consisted of a statement that the man was of good moral character, responsible, and dependable and provided a line for the reference's signature. Department policy is to question generic character reference letters. These references attest to the applicants' good character but do not indicate an awareness of their criminal history.

Although prohibited from doing so, the Caregiver Background Check Bureau accepted character references for an applicant that were written by facility employees.

To improve the consistency and usefulness of the character references it receives, a CBCB exemption manager told us the CBCB began to use a character reference form in November 2002. The form requires the reference to disclose how and how long the reference has known the applicant, his or her opinion of the applicant's character, how the applicant interacts with the pertinent client group, and other information the reference believes is relevant. However, the form does not mention the prohibition on references from facility employees and does not require references to consider the applicant's criminal history. These omissions limit the relevance of the information the CBCB receives from references and prevent the CBCB from receiving all the information it needs to approve or deny exemption requests.

THE CAREGIVER BACKGROUND CHECK BUREAU OFTEN DID NOT PERFORM CRIMINAL HISTORY CHECKS WITHIN ESTABLISHED TIME FRAMES

The CBCB has some fixed timelines for processing both the criminal history information that Justice provides and criminal history exemption requests, but it has not always been able to

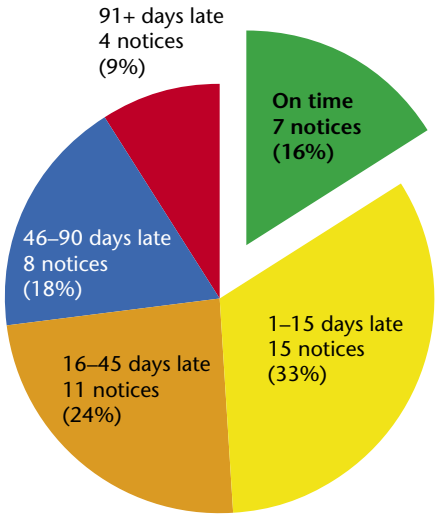
work within these timelines. In more than 80 percent of the cases we examined, the CBCB failed to notify the appropriate facilities or individuals within at most 15 days of receiving rap sheets from Justice that criminal history exemptions were needed. This represents a marked deterioration in performance since we reported the problem in the child care report. During the time period we reviewed, because the law and department guidelines permitted certain employees to start working while their criminal history reviews were pending, these delays potentially allowed people with dangerous criminal backgrounds to remain in facilities without adequate review of their criminal records. The CBCB's performance in promptly communicating to facilities and individuals the ultimate decisions on exemption requests also worsened since we issued the child care report, despite the CBCB extending its time frames for decisions from 45 days to 60 days. In July 2003 emergency regulations became effective that prohibit an individual from being in a licensed facility until the CBCB completes a criminal history review. This regulatory change addresses the concern that individuals with dangerous criminal backgrounds may begin work before the department has evaluated their criminal history. However, the CBCB's delays will also prevent individuals with less serious criminal histories from working until the CBCB completes its criminal history reviews. Thus, the CBCB's delays may impede a person's ability to work.

As we indicated above, when the CBCB receives a rap sheet, department guidelines require it to send the related facility and individual a notification that an exemption is needed. Depending on the severity of the crime(s) reported, the CBCB must send the notice within six to 15 days of receiving the rap sheet. Once the CBCB receives an exemption request, its current policy is to review and approve or deny the request, usually within 60 days. Before January 2002, the CBCB's policy was to render a decision in 45 days.

As Figure 2 on the following page indicates, in 38 of the 45 (84 percent) criminal history exemption requests we reviewed, the CBCB did not meet its guideline for notifying individuals and/or their facilities that they had to file for exemptions. In the child care report, we observed this same condition, but it affected substantially fewer of the initial notices the CBCB sent. Therefore, in the last two years, the CBCB's performance has significantly deteriorated in this area.

FIGURE 2

The Department's Record on Sending 45 Exemption-Needed Notices



In the case we reviewed with the longest delay, the CBCB allowed an individual to work in an adult residential care facility for more than 21 months, between August 2000 and June 2002, before sending an exemption-needed notice. The CBCB could not explain why it took so long to review this particular individual's rap sheet and notify her and her employer that she needed an exemption. Although it eventually granted an exemption for this individual, the CBCB had no way of knowing what the outcome would be during the long delay. Some of the other delays we observed occurred during a seven-month period, from September 2001 through April 2002. The manager of the CBCB's operation support unit (operations manager) explained that these delays resulted from the CBCB's installing a new database application. Although we found that system problems may explain some of the delays, we also observed persistent delays throughout 2001 and again in 2002—delays that were apparently unrelated to the CBCB's new database. In fact, for 22 of 28 (79 percent) rap sheets that we reviewed and the CBCB received outside the September 2001 to April 2002 period, the CBCB was late sending exemption-needed notices. The deputy director of the Community Care Licensing Division (licensing division) told us that the database system would be fully operational by July 2003. However, in July 2003, the operations branch chief told us that most system reports had been validated and were in use and the department hoped to have all reports operational in

October 2003. Moreover, the CBCB is restructuring its process for screening rap sheets so that a single staff person, instead of two, will be responsible for screening each rap sheet, updating the database, and assigning cases to exemption analysts. The department believes these changes will speed up its initial processing of rap sheets. We concur that these changes are likely to improve the CBCB's process because one person can more efficiently perform the several logically connected and simple steps.

Despite relaxing its standards, the Caregiver Background Check Bureau still struggled to grant criminal history exemptions promptly, issuing 44 percent of those we reviewed past its established timelines.

Once it received exemption requests, the CBCB also had difficulty issuing the actual exemption decisions on time. Even though the CBCB relaxed its time frame for rendering exemption decisions from 45 to 60 days during our testing period, the CBCB's on-time performance worsened since we issued the child care report, when 5 of 25 (20 percent) decisions we examined were sent late. In 20 of the 45 (44 percent) criminal history exemption approvals we examined, the CBCB did not meet its timeline in effect when the exemption decisions were made, even though there was nothing unusually complex about most of the cases. For example, the CBCB did not conduct a more thorough evaluation of these cases, nor did it obtain additional information from the individuals, the arresting agencies, or the courts before rendering a decision. Exemption managers' primary explanation for the delays was that the CBCB was experiencing high workloads at the time it processed these exemption requests.

The department recently reorganized the CBCB by shifting staff from other units to increase the number of analysts processing criminal history exemption requests from 11 to 16. Concurrently, one CBCB manager was reassigned to oversee the additional staff allocated to this function, and the department also plans to shift paraprofessional and support staff to each exemption unit team. The department believes a team approach will allow exemption analysts to redirect simpler tasks to other team members, thus speeding up the exemption decision-making process. Because the department reorganized the CBCB in 2003, it is too early to tell whether this approach will improve the timeliness of its decisions.

In addition, although during our test period the law required the CBCB to immediately ban from facilities caregivers who had been convicted of a felony while it contemplated an exemption request, the CBCB could use its discretion to exclude individuals with convictions for other crimes, including violent misdemeanors. In fact, we questioned the CBCB's decision not to ban four individuals convicted of violent misdemeanors.

However, in July 2003 the department's emergency regulations took effect prohibiting an individual's presence in a licensed facility before obtaining a criminal history clearance, which we discuss on page 31, or a criminal history exemption. Therefore, no individual—with or without a criminal history—will be allowed to work in a community care facility until the CBCB completes its initial background check process. Although the new regulations will help to ensure that potentially dangerous individuals with criminal histories are not present in a facility prior to the CBCB's review of their criminal history, individuals with minor criminal convictions or no criminal history will also be affected. For many, the department estimates its review will be a matter of a few days; others will take longer, up to 105 days, assuming the CBCB meets its exemption processing timelines once it receives an exemption request. Our review demonstrated that the CBCB does not always promptly send exemption-needed notices and make exemption decisions, potentially subjecting individuals with criminal histories to unreasonable delays prior to employment. Under its new regulations, the department must strike a fine balance between protecting vulnerable clients in community care facilities and ensuring that it does not impede an individual's right to work or a facility's ability to operate by taking an unnecessarily long time to complete its criminal history reviews.

Under the department's emergency regulations, no individual will be allowed to work in a community care facility before an initial background check is completed.

QUALITY CONTROL REVIEW OF EXEMPTION DECISIONS WAS NOT ALWAYS EFFECTIVE

Although the CBCB performed quality control reviews of exemption analysts' processing of exemption requests, we had one or more concerns with six of 17 cases that were subject to the CBCB's quality control process, indicating further improvement is necessary. As mentioned previously, the department's policy requires exemption analysts to consider all available information when reviewing an exemption request. The CBCB's quality control process is designed to help ensure that the exemption analysts reached the proper decisions based on the available information, including, but not limited to, rap sheets. In addition, the CBCB requires the quality assurance reviewer to verify that exemption analysts properly complete departmental forms and correctly draft letters communicating the exemption decision to the appropriate people and entities. If the quality assurance reviewer agrees with the exemption analyst's decision, it is the quality assurance reviewer's responsibility to ensure the proper letter is sent to communicate the decision.

However, we found that the CBCB's quality assurance reviewers sometimes failed to question cases for which exemption analysts had recommended approval despite missing documents or vague disclosures. In two cases, the applicants did not provide the CBCB with all required documents. Thus, the exemption analysts could not have made fully informed exemption decisions. In three other cases, the applicant provided either confusing or untruthful self-disclosure statements and the exemption analysts did not seek clarification. Despite these deficiencies, the quality assurance reviewers endorsed the analysts' exemption decisions without noting the problems or requiring additional follow-up.

Despite missing documents or vague disclosures, the Caregiver Background Check Bureau's quality assurance reviewers endorsed analysts' exemption decisions for five cases we reviewed.

In addition, the quality assurance reviewers twice failed to determine that appropriate administrative processes were followed where errors could have significant consequences. In one case, the exemption manager and the CBCB bureau chief each functioned as a quality assurance reviewer on a file and agreed an exemption was appropriate with the condition that the individual meet the terms of his probation. However, the exemption analyst sent the facility that employed the individual the wrong letter, which contained a standard approval without imposing the additional condition. The exemption manager said this occurred due to the exemption analyst's error. As a result of this case, the exemption manager indicated that the exemption analysts needed additional training to help ensure they properly communicate decisions. However, according to the department's policy, it was the quality assurance reviewer's responsibility to confirm that the exemption analyst drafted the correct letter and to order the letter if he or she agrees with the exemption analyst's decision. Although training the exemption analysts may prove beneficial, it does not address the CBCB's lax quality assurance reviews. The operations branch chief for the licensing division told us that the CBCB continues to change its quality control review process to improve its effectiveness. For example, he stated the department will develop improved procedures, and additional management staff are being redirected to complete quality control reviews.

THE DEPARTMENT COULD BETTER TRACK AND ASSESS ARREST-ONLY INFORMATION

As we noted earlier, the department has broad authority to grant exemptions to the law that prohibits anyone with a past criminal conviction from providing care or residing in a licensed

care facility. When conviction information is not available, the law also gives the department authority to use arrest records and other obtainable information to ban an individual from a facility if the department can prove that the individual poses a threat to the safety of community care clients. Justice and the department have an agreement that provides for Justice to send the CBCB criminal history information for all owners, operators, employees, and nonclient residents at licensed community care facilities. According to the department's evaluator manual, the CBCB's course of action depends on whether the information reflects a conviction or an arrest. For example:

- If the criminal history information reflects a conviction, it is evaluated using the exemption process described earlier.

- If the CBCB receives arrest-only information, which discloses arrests for crimes without convictions, the CBCB may refer the information to the department's Background Information Review Section (BIRS). The BIRS determines whether an investigation of the circumstances leading to the arrest is necessary.

For the department to take legal action to exclude an individual—that is, formally ban the individual from working, owning, or being present in a community care facility for at least one year—based on arrest-only information, the department must develop evidence admissible in an administrative hearing by investigating the arrest to show that the individual's poor conduct makes him or her unfit to be in contact with clients. Figure 3 diagrams the department's process of evaluating arrest-only information. The figure is simplified and does not include all possible outcomes. It also indicates areas in which the department's policy is not clear.

We expected the BIRS to have a process in place that did the following:

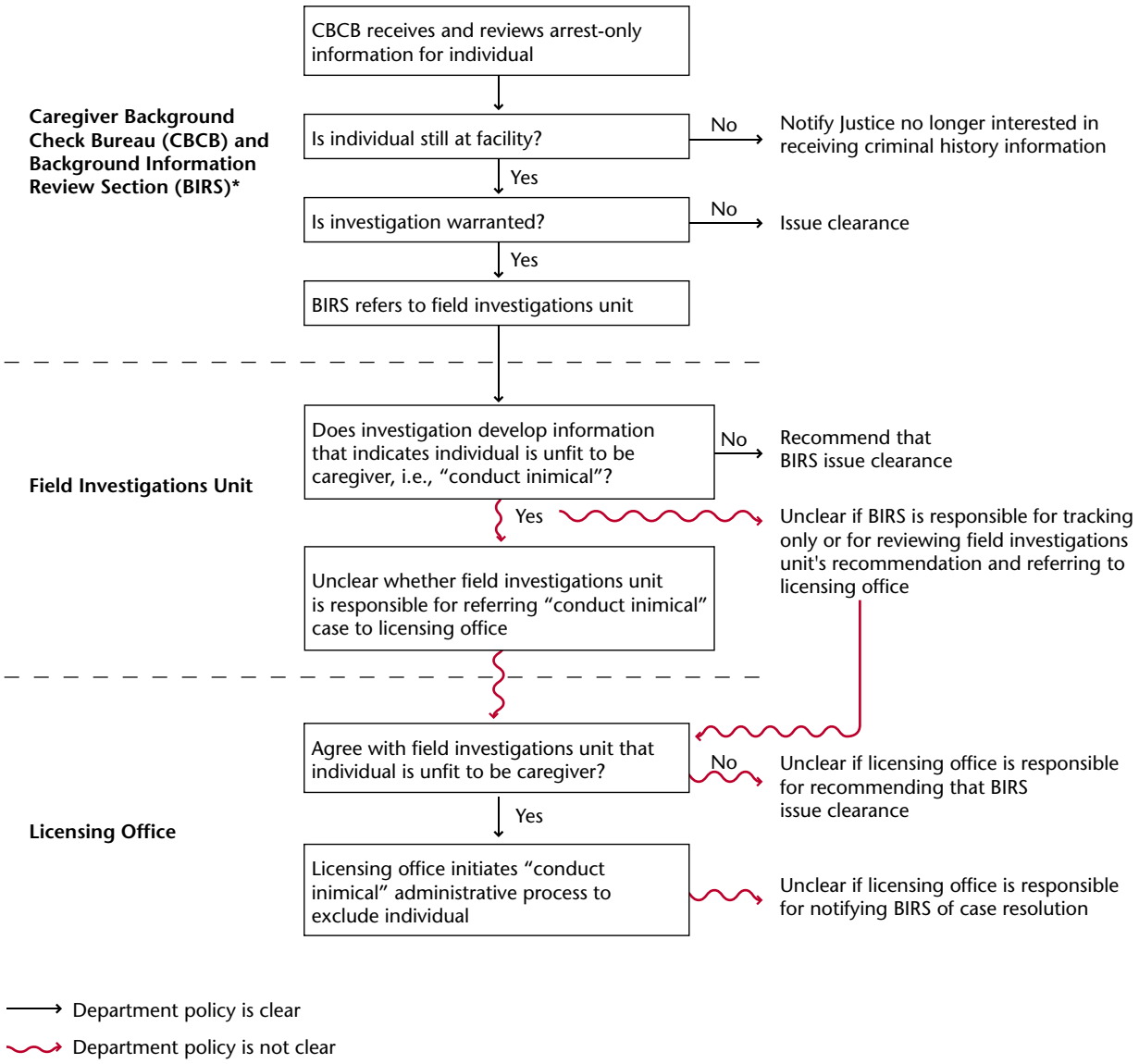
- Recorded when a case was referred to the field for investigation.

- Tracked a case to ensure that an investigation took place.

However, when the BIRS initiated an investigation, it failed to effectively track cases to their conclusion. Further, the BIRS manager told us that the BIRS has no systematic follow-up on cases it referred to the field to ensure an investigation is completed. As a result, necessary investigations may not have been completed, potentially exposing clients in community care facilities to unfit caregivers.

FIGURE 3

General Process for Handling Arrest-Only Information



* BIRS was removed from CBCB in March 2003 and became a part of the newly created Background Information and Investigations Branch.

In addition, we expected the BIRS' process to include procedures to ensure the necessary and appropriate action was taken at the conclusion of an investigation. According to the BIRS manager, the BIRS' responsibility is to track the progress of investigations through updates from field investigations and licensing offices. However, for three of the four cases we reviewed for which the BIRS determined an investigation was needed, it did not

effectively track the investigations to their conclusions. These three were part of approximately 170 cases in which the BIRS requested field investigations, and the BIRS manager could not tell us whether the department had taken the required actions. Included in the 170 cases was one involving a caregiver with an arrest for murder and another case of a caregiver with an arrest for multiple counts of rape and kidnapping; both cases were pending for more than 17 months since the field investigation had been completed. Furthermore, the individual with the murder charge was working in a foster care facility for two years after the field investigator recommended he be banned from the facility. After we inquired about the status of these cases, the BIRS manager determined that the individual with the murder charge had been legally excluded from working as a caregiver as of June 17, 2003, but the BIRS manager could not tell us the status of the individual with the rape and kidnapping charges.

As Figure 3 on the previous page indicates, the department's policies and procedures for processing and tracking arrest-only investigations are not always clear. For example, confusion exists about how field investigators are to report their recommendations on cases involving behavior that is considered "conduct inimical"—behavior so harmful or injurious, either in or out of a facility, that there may be a statutory basis to ban an individual from a licensed community care facility. It is clear that both the BIRS and licensing offices should be informed of the recommendation, but it is not clear if the field investigators are to inform the licensing offices directly, or indirectly, through the BIRS. The evaluator manual seems to direct the investigator to forward the results of the investigation directly to the licensing office and send a copy to the BIRS, whereas the field investigations transmittal form directs the investigator to only send the result of the investigation to the BIRS. The distinction is important because it is not clear who decides whether to proceed with an administrative action to exclude an individual from a facility based on his or her poor conduct. In fact, we found that staff were not certain whether field investigations or the BIRS was responsible for referring the case to the licensing office to determine whether to exclude an individual from the facility. Further, although the BIRS manager indicated the BIRS was responsible for tracking the status of cases, we found no clear instructions to licensing office staff to send their recommendations to the BIRS to issue clearances or to notify the BIRS when cases are referred for administrative action. Without clear communication to track the status of a case, it is

The department has not clearly directed staff as to who is responsible for referring a case for administrative action following an investigation.

possible that after determining that an individual is unfit to be a caregiver, the department would fail to take action to remove the individual.

The BIRS manager acknowledged that the BIRS' system of tracking investigations is confusing and inefficient. To improve its investigation tracking, the department plans to develop a new form that will clearly delineate where information should be sent. In addition, in May 2003, the deputy director of the licensing division told us that licensing offices are now responsible for making case decisions based on arrest-only investigations. Furthermore, the department recently combined the BIRS with its investigative functions in a newly created Background Information and Investigation Branch and modified work processes in the BIRS. The department believes these changes will streamline its investigations of arrest-only cases by centralizing information gathering and eliminating duplicate processes. In addition, the new branch manager will be charged with working closely with legal staff to facilitate case prosecution. Clarifying each unit's responsibility for taking and communicating action with a new form is a positive step toward ensuring a complete investigation. Also, by assigning the responsibility of arrest-only decisions to the licensing offices, the department further clarifies responsibility and conforms its practices to its policy. However, it is too early to tell whether the department's reorganization will achieve its desired effect: more effective handling and tracking of investigations.

WITHOUT ADEQUATELY REVIEWING AVAILABLE INFORMATION, THE DEPARTMENT SOMETIMES ISSUED CRIMINAL HISTORY CLEARANCES

The department did not always follow its policy and inappropriately issued clearances to people involved in court-mandated diversion programs.

If the arrest-only information reflects a crime the CBCB considers inconsequential, such as a vehicle code infraction, or if a field investigation initiated by the BIRS cannot develop sufficient information to legally exclude the individual, either unit will issue a criminal history clearance. In three of 25 cases with arrest-only information we examined, the CBCB (two cases) and the BIRS (one case) inappropriately issued criminal history clearances to individuals who were actively involved in court-mandated diversion programs. In these three cases—two cases involving welfare fraud and perjury and one case involving possession of a controlled substance—the CBCB and the BIRS failed to follow department policy of seeking additional information to determine whether the individuals were satisfactorily meeting the court's requirements.

In some instances, the courts can allow an individual to avoid a criminal conviction by participating in a work program, educational program, or rehabilitative counseling, all of which are considered diversion programs. If an individual successfully completes a diversion program, by law the department cannot use the arrest and the related diversion activity to exclude the individual from a licensed facility without the individual's permission. However, the department's procedures state it must determine, at a minimum, whether the individual successfully or unsuccessfully completed the diversion program before issuing a clearance. For an active diversion program, the department may use the arrest and the individual's progress in the diversion program in an arrest-only investigation. An additional, more significant, problem arose with one of the welfare fraud cases. Before the CBCB issued a criminal history clearance for the case, the individual's diversion was terminated and she was convicted of a misdemeanor. The CBCB was not aware of the termination and conviction because it did not check the status of the diversion. As a result, it cleared this person instead of notifying her and her employer that a criminal history exemption was required for continued employment.

When Criminal History Clearances Are Issued

- Justice issues a criminal history clearance if the individual has no criminal record.
- The department issues a criminal history clearance if the CBCB determines that the individual's criminal record comprises an inconsequential offense, such as a traffic violation, or an individual's criminal history information reflects an arrest or arrests only, no convictions, and the department cannot gather sufficient information to exclude the individual.

Speaking on behalf of both the CBCB and the BIRS, the BIRS manager acknowledged the practice differs from the policy described in the evaluator manual. The CBCB's operations manager added that the CBCB issues clearances only in cases involving nonserious crimes and concluded that because Justice provides more data if an individual with arrest-only information is convicted, the department does not expose clients to immediate risk. However, the operations manager was mistaken about Justice's practice. The assistant bureau chief of Justice's Bureau of Criminal Identification and Information told us that Justice does not send the department subsequent disposition information, such as convictions, after sending arrest-only information. She told us there was no statutory mandate to send subsequent disposition information and no funding available for the necessary programming changes or additional staff to perform this function. By clearing individuals currently participating in diversion programs, we believe that the CBCB and the BIRS risk ignoring important information that could be used to better protect clients in community care facilities.

The operations branch chief of the licensing division acknowledged that the department did not have clear expectations for handling diversion cases. He told us that recently the department implemented policies to ensure there is an investigation of the underlying facts for cases in which an individual is placed in a diversion program. Individuals in diversion programs will not be cleared until an investigation is completed. However, the department already had policy in effect that, if followed, would have prevented it from issuing a clearance to an individual in a diversion program without an investigation of the facts. Moreover, because the CBCB did not follow department policy and Justice does not notify the CBCB if a diversion program is cancelled and a conviction results, the CBCB may not know of convicted individuals working in community care facilities.

JUSTICE DID ITS PART AS REQUIRED, BUT THE CAREGIVER BACKGROUND CHECK BUREAU'S HANDLING OF SUBSEQUENT CRIMINAL INFORMATION WAS WEAK

Justice sends the CBCB subsequent rap sheets (subraps) to notify the CBCB of crimes for which caregivers or others at a facility have been arrested or convicted after the CBCB conducts its initial criminal history review. However, significant problems exist in the way the CBCB processes subrap information it receives from Justice. For example, the CBCB did not have adequate procedures for tracking its handling of subraps and sometimes did not record when it had received them. By not tracking its process, the CBCB was unable to effectively monitor whether it promptly considered subraps to protect clients in community care facilities. Furthermore, the CBCB was slow to notify facilities when exemptions were needed based on conviction information in subraps and did not notify its licensing offices when individuals could no longer be present in facilities because they failed to respond to these notices. Because of these delays, the CBCB sometimes allowed individuals unfit to be caregivers to remain in that role. Although the CBCB has problems properly handling the information, it appears that Justice has improved its systems and is now able to send subraps to the CBCB in a timely manner.

The Caregiver Background Check Bureau Did Not Consistently Record Receipt of Subraps

The CBCB did not always adequately record in its database the subraps it received from Justice, making it difficult to track where in the CBCB the subraps are eventually sent and what

is eventually done with them. Consequently, some individuals may have continued as caregivers despite additional criminal histories that could render them unfit for that role. Instead of recording in its system the date it received a subrap, according to the operations manager, the CBCB recorded the date it assigned the subrap for review.

We selected 25 subraps for review, and Justice provided us with copies. However, nine of the 25 subraps did not appear in the database in which the CBCB should record the receipt of all subraps. Of those nine subraps, the CBCB was able to locate three that were in active case files and speculated that one was destroyed because the individual was no longer a caregiver at a licensed facility. The CBCB could not explain what happened to the remaining five. The operations manager told us that, for 12 other subraps that appeared to have been received late, the CBCB recorded the dates it assigned the subraps to exemption or BIRS analysts for review. Based on the CBCB's database, it incorrectly appeared the CBCB received these subraps 12 to 238 days after Justice sent them. Because the CBCB did not accurately or consistently record the date it received each subrap, the CBCB could not ensure that it properly considered all subraps for exemption request reviews or arrest-only investigations, nor could it track the timeliness of its actions. Although, in response to our concerns, the CBCB's operations manager indicated it would begin to accurately record the dates it receives all subraps, it is too early to tell whether the CBCB will effectively and consistently track subraps.

The Caregiver Background Check Bureau Was Slow to Notify Facilities and the Licensing Offices When an Individual Needed an Exemption for a Conviction Reported on a Subrap

In 11 of the 14 subraps with convictions that we examined, the Caregiver Background Check Bureau was late in sending its exemption-needed notices.

The CBCB was slow to notify the appropriate facilities that it had received subraps and that the facilities must request exemptions. In 11 of the 14 subraps with convictions that we examined, the CBCB was late in sending its exemption-needed notices. Before January 2002, the CBCB had a six-day standard to send exemption-needed notices for felony and violent misdemeanor convictions, but it was unable to always meet this standard. In one case, after receiving a caregiver's subrap reflecting a felony conviction for welfare fraud, the CBCB did not notify her employer until 104 days past the six-day deadline that an exemption was needed. The CBCB eventually denied the exemption request for this individual.

In the case of a felony or violent misdemeanor conviction, the CBCB's current standard is to send an exemption-needed notice within eight days of receiving a subrap, but the CBCB is not always able to meet this more relaxed timeline. For example, the CBCB sent one exemption-needed notice for a subsequent misdemeanor battery conviction 88 days after its eight-day standard. The CBCB eventually denied the exemption request for this individual. The department's standard is in place to establish a time frame for it to evaluate whether a person in a facility presents a risk to the facility's clients. By failing to send timely exemption-needed notices, the CBCB allows individuals to continue working as caregivers even though they might present a risk to clients in care facilities. Although the department's emergency regulations effective July 2003 prohibit individuals with criminal convictions from being present in a community care facility until the CBCB grants them a criminal history exemption, the same is not always true for individuals who have been convicted of crimes after the CBCB has conducted its initial criminal history review. Under its emergency regulations, the CBCB has the discretion of allowing these individuals to remain in community care facilities while it assesses the risk posed to clients in community care resulting from the individuals' new convictions.

Similarly, the CBCB did not always meet its timelines for notifying the appropriate facility and licensing office that an individual had not submitted an exemption request. No one with a criminal history who requires, but does not request an exemption, can own, operate, work in, or live in any community care facility. After the CBCB sends an exemption-needed notice, a facility or the affected individual must request an exemption within 30 days. Two exemption managers told us that if the CBCB does not receive a request within 45 days, its practice is to notify the facility and the appropriate licensing office that the individual may no longer be present in the facility. However, the CBCB failed to meet its guideline in four of eight cases we reviewed. In one case, the CBCB did not send the notice until after we inquired about the status of the case—nine weeks late. With delays of these notifications, analysts in the department's licensing offices do not have accurate information about who should or should not be in a facility. This reduces the analysts' ability to help ensure clients' safety.

By Improving Its Efficiency in Processing Subraps, Justice Has Eliminated Backlogs

Justice has streamlined its subrap processing procedures and has more quickly and accurately notified the Caregiver Background Check Bureau about subraps.

Since we issued the child care report, in which we recommended Justice change its system for reporting subraps, Justice has streamlined its procedures for subrap processing and now forwards most subraps to the CBCB within a few days. Before July 2002, agencies did not certify that a pending arrest was still active, rather than resulting in a detention only, when they sent arrest information to Justice. As a result of the lack of certification, Justice had to contact the arresting agencies to verify the status of each arrest, causing delays in transmission of arrest information to the CBCB. However, most arresting authorities now use an electronic transmission method to send Justice an individual's fingerprints and, as of July 2002, certification that an arrest is still active. Therefore, on receiving arrest information, Justice can forward it to the CBCB quickly without having to contact the arresting authority to reconfirm the information. Furthermore, Justice has enhanced its computer system to eliminate the need to complete some of its processes manually, such as updating its automated criminal history system with new arrest information. These computer enhancements save Justice additional time and reduce the likelihood of errors.

Before improving its system, Justice allowed significant numbers of subraps to accumulate. According to the assistant bureau chief of Justice's Bureau of Criminal Identification and Information, Justice focused its resources on supplying various agencies with initial necessary criminal history data and made its subrap processing a lower priority. She also told us that the volume of subsequent arrests nearly doubled between fiscal years 1998–99 and 2001–02 and that Justice's manual system for verifying the status of arrest-only rap sheets was labor-intensive and time-consuming, and Justice's resources were inadequate. The assistant bureau chief told us that between June 2002 and September 2002 Justice temporarily redirected staff to clear its subrap backlog. Currently, Justice believes that significant subrap backlogs will not develop because of its streamlined process, and arresting agencies transmit 95 percent of arrests electronically.

Internal correspondence at the department indicates that Justice sent the CBCB approximately 29,000 records between July 2002 and October 2002 due to Justice's effort to reduce its backlog of subraps. The CBCB's operations manager told us the CBCB handled subraps with more serious crimes, such as felonies or violent misdemeanors, but allowed backlogs to develop for subraps with less serious crimes. She also told us that

in November 2002, the CBCB redirected staff to process these less serious records. Through a series of screening processes, the CBCB determined that 1,659 arrest-only cases, including 592 for cases involving arrests for more serious crimes, needed some investigation. According to the chief of Investigation Services, as of July 2003 initial investigations were completed and forwarded for legal review. Of the 592 more serious arrest-only cases, legal has requested additional investigation on 522, but has not decided whether to file an administrative action for 70 cases.

UNDER THE CAREGIVER BACKGROUND CHECK BUREAU'S CURRENT CRIMINAL HISTORY REVIEW PROCEDURES, CERTAIN OUT-OF-STATE CRIMES MAY GO UNDETECTED

If an individual leaves a community care facility and returns to work within two years, the CBCB may not be aware of that individual's complete criminal record for the two-year period. To meet the Health and Safety Code requirement that it maintain criminal record clearances for two years after a caregiver or adult nonclient resident is no longer in a facility, the CBCB receives subraps from Justice disclosing any in-state criminal activity over the two-year period. Department policy is to rely on these ongoing disclosures and not require a full criminal background check when these individuals return to work in a licensed facility. As a result, a caregiver or nonclient resident could leave a facility, be arrested or convicted of a crime outside of the State, which would not appear in Justice's subraps, and then return to a facility within two years without the CBCB knowing about the criminal activity. Unlike Justice, according to the operations branch chief of the licensing division, the Federal Bureau of Investigation does not offer a subrap service. However, he acknowledged that the problem we outlined exists, and stated that the department would continue to look at the issue.

JUSTICE CONTINUES TO IMPROVE ARREST AND CONVICTION REPORTING THROUGH USE OF AUTOMATED SYSTEMS AND TRAINING

California law requires all city, county, and state criminal justice agencies and courts (reporting agencies) to report to Justice any arrest and disposition—a conviction, acquittal, or dismissal. Justice uses these data to compile its criminal history database information, which it then provides to the department for use in criminal history reviews. Complete and accurate criminal

history information enables the department to make more fully informed licensing decisions for community care facilities. As we stated in the child care report, reporting agencies did not always send Justice all arrest and conviction information. At the time, Justice estimated that reporting agencies did not report 20 percent to 25 percent of arrests or dispositions. Although according to Justice's data as of April 2002, reporting agencies still fall short of submitting to Justice 100 percent of their arrests and dispositions, Justice is making improvements to increase reporting through use of automated systems and training. Using incomplete crime information severely limits the department's ability to make well-informed criminal history assessments and increases its risk of allowing someone with a potentially threatening criminal history to care for or come in contact with clients in a community care facility.

Justice reports it has automated systems that increase the reporting of criminal history information.

Since we issued the child care report, Justice reports that it has continued to implement and has further developed automated systems that not only increase criminal history reporting but also ensure that reporting agencies submit arrest and disposition information more quickly and with fewer errors. Justice continues to promote automated systems such as the electronic transmission of fingerprints and electronic access to reporting agencies' records. Justice reported that in 1999 there were only 144 terminals capable of transmitting fingerprints electronically but as of April 2002 indicated there were more than 1,100 terminals throughout the State. Justice also reports that it designed and implemented a system known as "direct access," which allows it remote access to law enforcement and court databases to obtain arrest and disposition information missing from records the reporting agencies submit. In January 1999, Justice had direct access to reporting agencies' databases in only five counties, but in April 2002 reported it could access missing information in 16 counties. According to the assistant bureau chief of Justice's Bureau of Criminal Identification and Information, Justice plans to expand its direct access system to seven more counties by early 2004. In April 2002 Justice estimated that with reporting agencies using automated systems, overall arrest reporting increased to 95 percent and overall disposition reporting was up to 88 percent. Justice is also attempting to increase reporting through training for reporting agencies, making them aware of the importance of timely arrest and disposition reporting. Although the steps Justice has taken are clearly beneficial, Justice needs to extend implementation of its automated systems to all counties to help resolve the problem of nonreporting of arrest and disposition information.

RECOMMENDATIONS

To ensure that criminal history exemptions are not granted to individuals who may pose a threat to the health and safety of clients in community care facilities, the department should:

- Make certain it has clear policies and procedures for granting criminal history exemptions.

- Ensure staff are trained on the types of information they should obtain and review when considering a criminal history exemption, such as clarifying self-disclosed crimes and vague character references.

- Revise its character reference form to be certain the form's instructions are fully consistent with criminal history exemption guidelines.

To process criminal history reviews as quickly as possible so that delays do not impede individuals' right to work or its licensed facilities' ability to operate efficiently, the department should work to make certain that staff meet established time frames for notifying individuals that they must request a criminal history exemption and for making exemption decisions as requested.

The department should assess its quality control review process and ensure that these policies and procedures encompass a review of the key elements of the exemption decision process and staffs' completion of appropriate and necessary correspondence.

So that investigations of arrest-only information are properly tracked, the department should develop a process for the BIRS to:

- Record when it refers a case for investigation.

- Track a case to make certain that an investigation takes place.

In addition, the department should ensure that policies and procedures are consistent and clear on where the responsibility lies for ensuring that the necessary action occurs upon an investigation's completion.

The department should review and enforce its arrest-only policies and procedures to ensure that it is issuing criminal history clearances only when appropriate to do so. In addition, the department should properly train staff on these policies and procedures.

The department and Justice should work together to identify what, if any, additional information, such as convictions or diversions, the department may need to make reasonable and appropriate criminal history decisions after receiving arrest-only information. They should then arrange for Justice to provide the needed information.

To ensure the department can account for all subraps it receives and that it processes this information promptly, the department should develop and implement a policy for recording a subrap's receipt and train staff on this policy. In addition, upon receiving a subrap with a conviction, the department should ensure that staff meet established time frames for notifying individuals that they need an exemption.

So that the department's licensing staff have accurate information about who should or should not be in a facility, thereby helping to protect clients, the department should meet its established time frame for notifying licensing staff and facility owners/operators that an individual has not submitted a criminal history exemption request as necessary and may no longer be present in a facility.

The department should assess its Federal Bureau of Investigation background check practices to ensure that it is fully aware of an individual's criminal record should that individual have a two-year or less gap in employment in community care.

Justice should continue to implement and further develop automated systems that not only increase criminal history reporting, but also ensure that reporting agencies submit arrest and disposition information more quickly and with fewer errors. ■

CHAPTER 2

Shortcomings Prevent the Department of Social Services From Effectively Protecting All Clients Against Unsafe and Unhealthy Environments in Community Care Facilities

CHAPTER SUMMARY

The Department of Social Services (department), through its Community Care Licensing Division (licensing division), licenses, monitors, and investigates complaints against licensed community care facilities. However, licensing offices that we visited did not always perform their duties as required, possibly putting the health and safety of clients at risk. Specifically, the licensing offices did not always follow the department's procedures for addressing complaints, such as ensuring that community care facilities fully correct identified deficiencies. Consequently, the department might have prolonged clients' exposure to unsafe and unhealthy environments. Moreover, our review found that certified parents—foster parents certified by a foster family agency—may avoid correcting their deficiencies by simply switching to another foster family agency. This can occur because foster family agencies are not required to inquire into applicants' compliance history before certifying a foster family home. Certifying foster parents without a review of the applicant's compliance history could expose foster children to dangerous environments.

Although statutorily required to do so, the department did not always perform annual on-site facility evaluations. In fact, the department has placed annual facility visits low on its priority list and, effective October 2002, began allowing staff to defer visits to facilities that meet certain criteria. However, licensing offices did not consistently follow the criteria necessary to defer visits. Consequently, the department may have been unaware of licensing violations that could have posed dangers to children, adults, and seniors in care. Moreover, before granting facility licenses to applicants, licensing offices did not consistently obtain all the information needed to demonstrate applicants' abilities to effectively and responsibly care for clients.

By licensing individuals before considering all the required information, the department may have licensed people unfit to care for vulnerable clients. Finally, the adult and senior care programs' oversight of staff that carries out most of the licensing function was weak, and all programs did not always train these employees as statutorily required. As a result, the department had limited assurance that its staff had the proper skills for administering the community care programs.

THE DEPARTMENT DID NOT ALWAYS FOLLOW REQUIRED COMPLAINT PROCEDURES

The department investigates complaints against licensed care facilities to ensure that caregivers are providing safe and healthy environments for their clients. Although it has formal procedures for addressing complaints, the department did not consistently follow them. It did not always ensure full correction of deficiencies noted, did not meet required time frames to ensure the immediate safety of clients at risk, and did not follow all the required procedures for complaints involving serious allegations, such as sexual and physical abuse. Because the department did not always follow its complaint procedures, it is less sure that clients were safe from potential dangers, such as maltreatment and unclean facilities.

The Department Has a Process to Review Complaints It Receives About Licensed Community Care Facilities

By law, anyone can register a complaint with the department against a licensed community care facility. A complaint is an allegation that a facility owner, operator, employee, or adult nonclient resident has violated a licensing law or regulation. The department must investigate all complaints it receives that raise reasonable questions about potential violations of licensing regulations and then make certain that substantiated complaints—those the department can show are true—are corrected.

The department begins a complaint investigation of a licensed facility by making an unannounced facility visit. After gathering and evaluating evidence, the department can make one of the following resolutions about the complaint:

- Substantiated: There is a preponderance of evidence that the allegation is valid.

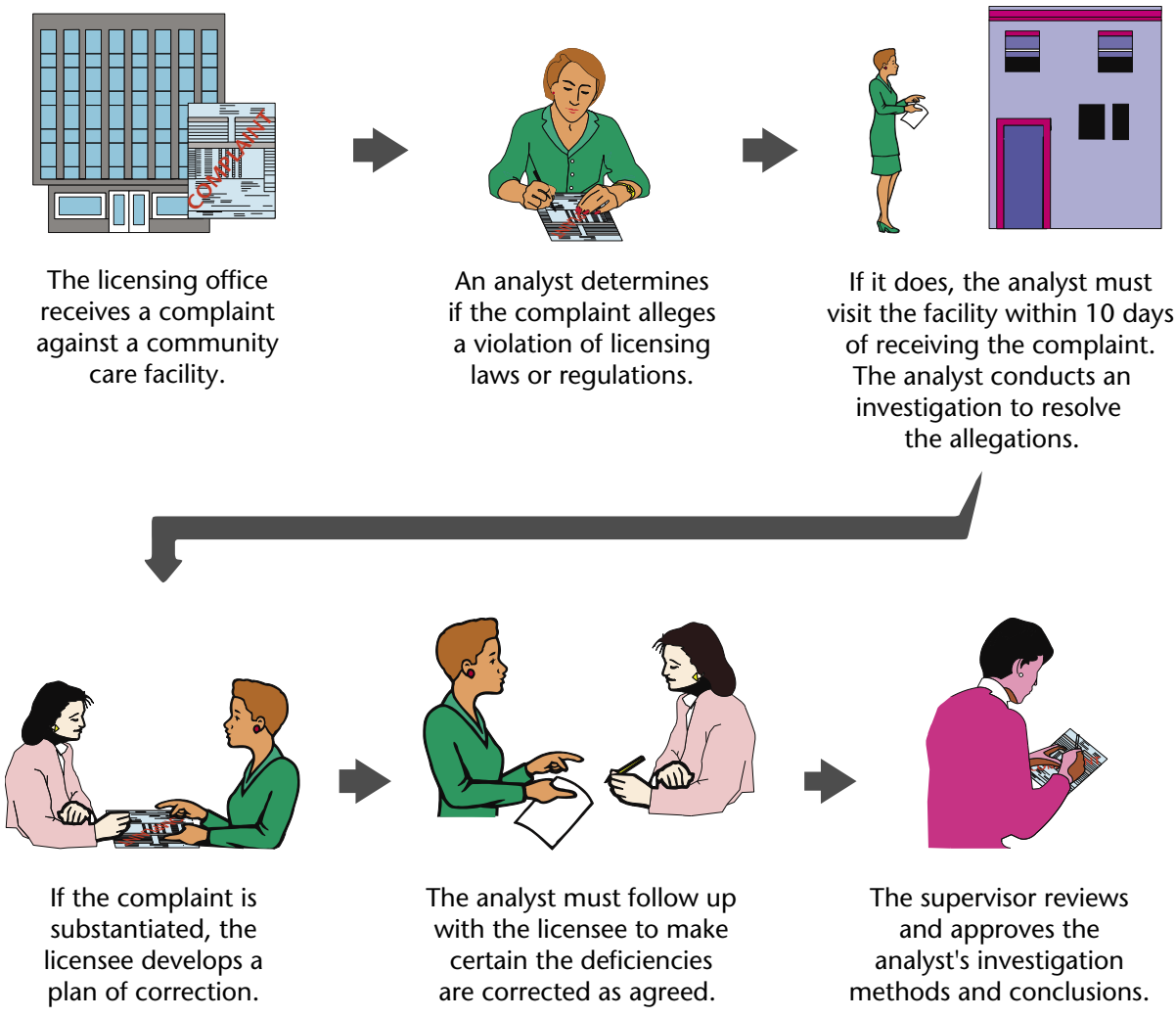
- Inconclusive: The alleged action may have happened, but there is not a preponderance of evidence to prove it is valid.

- Unfounded: The allegation is false, could not have happened, or is without a reasonable basis.

If the department substantiates a complaint, it cites the facility's deficiencies and typically requires the caregiver to develop a corrective action plan to remedy the deficiencies. Figure 4 summarizes the department's complaint process.

FIGURE 4

The Department's Complaint Process



Note: For certain kinds of complaints, the department takes additional steps not reflected in this figure.

The Department Did Not Consistently Ensure Facilities Corrected Identified Deficiencies

The department asserts that most of the corrective actions it undertakes are identified through its complaint process rather than other facility evaluations. However, when licensing analysts (analysts) identified facilities' deficiencies during complaint investigations, they did not always ensure that caregivers complied with the corrective action plans. We reported a similar issue in our August 2000 report, *Department of Social Services: To Ensure Safe, Licensed Child Care Facilities, It Needs to More Diligently Assess Criminal Histories, Monitor Facilities, and Enforce Disciplinary Decisions* (child care report).

For 11 of the 33 substantiated complaints we reviewed, the department could not demonstrate that the facilities completely corrected the problems that prompted the complaints.

For 11 of the 33 substantiated complaints we reviewed for the current audit, the department could not demonstrate that the facilities completely corrected the problems that prompted the complaints. For example, in October 2002, an analyst substantiated a complaint against foster parents that one foster child was having sexual contact with another foster child. Based on his investigation, the analyst determined there was opportunity for the sexual contact because the foster parents improperly supervised the children despite knowing that one of the children had a history of "sexually acting out." The corrective action plan required the foster parents to obtain additional training and counseling to help them recognize warning signs and prevent recurrences of the sexual contact. However, after creating this corrective action plan, the analyst failed to follow up with the foster parents to determine whether they actually sought and received the prescribed training and counseling.

Regarding another certified family home, the department received allegations of personal rights violations and neglect, among other concerns. After visiting the home and interviewing witnesses, the analyst substantiated allegations, including that the foster parent used insulting language with the children, threatened to slap them, and left the children unsupervised. The analyst also noted in the complaint investigation that these were recurring issues. Despite this history and substantiation of the latest allegations, the analyst did not cite the foster parent's deficiencies, create a corrective action plan, and follow up to ensure that the foster parent corrected the deficiencies.

According to the department's policies and procedures, an analyst must ensure that a facility licensee completely corrects deficiencies identified during a complaint investigation, and that a supervisor must review and approve of the analyst's

complaint investigation to ensure that all the proper steps to resolve the complaint were taken. However, of the 11 complaint investigations we reviewed that lacked adequate follow-up, 10 had been reviewed and approved by supervisors. Because a complaint may identify a situation that could result in significant harm to clients, we raised a concern in our child care report that the department did not require supervisors to be a part of the final, critical stage of the complaint process: making certain the deficiency is corrected. Consequently, the department updated its policies, requiring that a supervisor be satisfied with the follow-up before signing off on a complaint. However, based on the results of our current review, it does not appear that supervisors' reviews are rigorous enough, especially given the seriousness of some of the complaints, as mentioned previously. In spite of analysts' improper handling of these complaints, supervisors signed off on the complaints, signaling approval of the analysts' actions. When supervisors do not thoroughly review complaints to ensure that caregivers completely correct deficiencies, we believe the probability increases that analysts will overlook follow-ups. Furthermore, by not following through to see that corrections are made, the department negates its efforts in investigating and substantiating complaints.

The Department Did Not Always Conduct Site Visits or Resolve Complaint Investigations Within Established Time Frames

For 19 of the 75 complaints we reviewed, the department did not make its initial facility visit within 10 days, as required by law.

Although laws and procedures designed to protect clients' welfare mandate certain time frames within which the department must initiate and follow through on complaint investigations, it did not always do so. The law requires the department to conduct an initial visit to a facility within 10 days of receiving a complaint, unless there is a valid reason to delay the visit, such as the potential for the visit to interfere with an ongoing police investigation. Our review of 75 complaints the department received in 2001 and 2002 identified 19 complaints for which the department made its initial facility visits beyond the 10-day requirement. The visits ranged from two to 175 days late, and the Sacramento licensing office accounted for 15 of the 19 late visits. In one instance, the Sacramento licensing office received a complaint in April 2001, alleging that on three separate occasions, a foster child had suspicious marks on or near the diaper area, which suggested physical abuse. However, the analyst assigned to investigate the complaint did not visit the foster child's home until October 2001, 175 days beyond the 10-day requirement. The department cited in a report its caseload as the cause of the lengthy delay. However, we do not believe that

caseload is a reasonable cause for delaying complaints involving abuse, especially given the department's policy of considering abuse allegations a top priority. Whenever the department delays an initial facility visit following receipt of a complaint, the department runs the risk of perpetuating a client's exposure to the alleged harmful conditions.

The department also has a policy to complete complaint investigations within 90 days of making its initial facility visits. However, 10 of the 75 complaint investigations we reviewed took longer to complete than the department's 90-day policy allows. For example, in June 2001, the department received an allegation that a caregiver kicked an elderly resident in the face and twisted another's arm. Although an analyst conducted the initial facility visit within the required 10 days, the analyst took 10 months to decide that she could not conclude on the validity of the allegations. The length of the investigation may have contributed to the inconclusive finding, as it seems reasonable that over time, evidence would be harder to gather. In another example, the department took more than seven months to resolve a complaint alleging that a foster parent kicked a foster child in the ribs. The supervisor overseeing this investigation contended that difficulties scheduling interviews caused by heavy workloads and other activities led to the lengthy investigation. The analyst also had a difficult time contacting the caregiver, which led to an initial visit later than the 10-day requirement. Meanwhile, the foster child remained in the home and was potentially exposed to further maltreatment while the assigned analyst investigated this complaint.

The department's guidelines state that investigations should not exceed 90 days, which we interpret as a requirement. The department indicated that analysts and supervisors do not view the 90 days as a mandate and that the staff's primary goal is the assurance of acquiring complete and substantive evidence, a goal that would take precedence over meeting a quantitative time frame of 90 days. We agree that taking time to be thorough is important, but the explanations offered to us implied that other work and priorities had delayed their investigation, not a deliberative focus on the investigations. As we mentioned above, not only does resolving complaints expeditiously help assure the department that clients are safe from harmful conditions and that caregivers correct their deficiencies promptly, it also increases the likelihood that analysts will obtain evidence to determine whether a complaint is valid or baseless. For instance, witnesses or victims may more easily recall a particular situation

when an analyst interviews them closer to the date of the incident, rather than later; physical evidence, such as spanking marks and bruises, may also be more obvious. By resolving complaints as quickly as possible, the department is more likely to meet its goal of acquiring complete and substantive evidence.

The Department Did Not Always Follow Required Procedures for Abuse Allegations

Because complaints alleging abuse represent a serious threat to the clients' well-being, the department's policies specify that abuse complaints are a top priority and require analysts and supervisors to handle these complaints differently from routine complaint investigations. However, the department did not consistently follow these special procedures for the top-priority allegations among the 75 complaints we reviewed.

For instance, when the department receives complaints alleging any sexual or certain physical abuse, it must hand them over to the field investigators, the staff responsible for investigating abuse allegations. The field investigators have the discretion to accept or reject abuse complaints based on the seriousness of the allegations and the unit's workload. When the field investigators reject a complaint, the licensing office is responsible for investigating the allegations. However, of the 75 complaints we reviewed, the department did not refer two of 22 complaints to the field investigators as required and did not send another three within the required time frame of eight working hours after receiving the complaint. In one complaint alleging that a foster mother hit her foster children, the department waited seven days to forward the complaint to the field investigators. When analysts do not refer or are slow to refer serious complaints to the field investigators, the analysts risk jeopardizing the expeditious handling of complaints and may affect the immediate safety of vulnerable clients.

Another special procedure for top-priority complaints is required when analysts cannot make conclusive decisions on any sexual abuse allegations and certain physical abuse allegations. When analysts cannot determine whether such alleged abuse did or did not occur, the department's procedures require licensing office supervisors to consult with the department's legal division. This requirement seems reasonable especially considering the serious nature of sexual and physical abuse allegations because it helps assure that analysts gather necessary evidence and draw proper conclusions based on the evidence. However, in our review of

Although required to do so, supervisors failed to consult with the legal division in five of the 13 cases of alleged abuse we reviewed.

13 complaints alleging sexual or physical abuse for which the analysts drew inconclusive resolutions, the supervisors failed to consult with the legal division in five cases. By not consulting with the legal division, the department reduces its assurance that it has appropriately resolved inconclusive cases that could, if unresolved, leave clients in harmful environments and the department vulnerable to liability claims.

In addition to not always forwarding abuse complaints to the legal division, analysts did not consistently meet the department's 10-day requirement to cite licensees for the violations. Once the field investigators complete their work on a complaint, they send their findings to the appropriate licensing office, which is then responsible for any necessary follow-up and corrective action. In response to a recommendation in our child care report, the department began to require its analysts to issue a citation for a violation within 10 days of receiving the field investigators' reports, rather than the previous time frame of 30 days. In issuing a citation, the analyst is making the caregiver aware of specific licensing violations. However, of six complaints we reviewed, the analysts did not issue four citations as necessary within the specified time frame. In one case, the department received allegations of sexual abuse and lack of supervision against a certified family home. The field investigator did not substantiate the allegation of sexual abuse but did substantiate that a foster parent allowed a minor to go to a neighbor's home unsupervised even though the neighbor lacked the necessary background clearances for supervising foster children. After receiving the field investigator's findings, the analyst waited 113 days to cite the foster parent. Thus, the potential for recurrence remained high because the foster parent may not have been aware that the department would take action against her. Additionally, by not notifying the foster parent of her licensing violations, the analyst further delayed the corrective action.

CERTIFIED FAMILY HOMES MAY HAVE AVOIDED CORRECTING THEIR DEFICIENCIES BY CHANGING CERTIFICATION FROM ONE FOSTER FAMILY AGENCY TO ANOTHER

The department is responsible for licensing foster family agencies—private nonprofit corporations that in turn certify adults (certified parents) to operate foster family homes (certified family homes). Although the department does not certify family homes, it is responsible for investigating complaints

against them. When the department substantiates or confirms a complaint against a certified family home, it must make sure the certified parent corrects the deficiencies. However, because the department does not require foster family agencies to request information about applicants' compliance histories, the opportunity exists for certified parents to avoid correcting identified deficiencies. In one complaint investigation we reviewed, an analyst substantiated numerous complaints against a certified family home, including threats of abuse and inadequate supervision. At about the same time, the foster family agency voluntarily decertified the home. In this case, the department accepted the foster family agency's decertification of the home as corrective action for the complaint. However, even before the department completed its investigation, the woman applied and was certified by a new foster family agency without the department making certain that the issues underlying the complaint had been resolved.

In another example, the department required a foster family agency to decertify a parent for physically abusing foster children placed in her care. Nevertheless, she was able to obtain certification from another foster family agency, and the department ordered the new foster family agency to decertify the parent due to her history of abusing foster children. On the woman's third attempt to be certified under still another foster family agency, the department took legal action that prevented other foster family agencies from certifying her.

The adults in these examples were able to move to new foster family agencies because the laws and regulations do not require a foster family agency to take specific steps when certifying homes that could prevent this from happening. Although the department must be sure that a foster family agency has a process in place to guarantee that it certifies only homes that meet licensing requirements, the laws and regulations do not require a foster family agency's process to include contacting an applicant's immediate prior foster family agency or the department about the applicant's past performance, including information about substantiated but uncorrected complaints. Nor must the foster family agency's process include requiring an applicant to disclose her or his performance history. Consequently, foster family agencies may not have all available information when certifying adults and may, as a result, leave children subject to maltreatment.

WEAKNESSES EXIST IN THE DEPARTMENT'S LICENSING ACTIVITIES

When making its decision to license a new facility, the department does not always demonstrate that it collects and considers all required information and documents that help ensure the safety of vulnerable clients, such as evidence that the applicant obtained the necessary health screening and client care training. In addition, the department does not consistently conduct all necessary post-licensing evaluations or ensure that the visits it does perform are made within statutory timelines. By failing to conduct all required post-licensing visits or doing so late, the department has less assurance that newly licensed facilities comply with regulations and potentially jeopardizes the health and safety of clients in care at the facilities.

The Department Sometimes Granted Facility Licenses Based on Incomplete Applications

The department could not demonstrate that it always collected and considered all necessary information before it issued facility licenses. Table 3 shows the principal requirements that an applicant and the department must fulfill as part of the community care licensing process.

Of the 54 licenses we reviewed that the department granted during 2001 and 2002, the department granted 12 licenses before the applicants met one or more of the necessary requirements, including providing a health screening report or an administrator's certification. The department granted two applicants a license to operate a foster family home before the applicants' child abuse central index checks—a review the department performs for reports of child abuse—were complete. Although both applicants obtained the child abuse central index clearances four days later, the department cannot demonstrate that it considered the applicant's suitability to care for children before granting the license. Seven of the 12 licenses we questioned were granted by the Sacramento licensing office. According to the program administrator for foster care, much of the missing information was caused by the analysts' oversight. In addition, an analyst made a procedural error by entering an incorrect licensing date, which made it appear as though the analyst had not obtained the child abuse clearances before licensing these applicants. Finally, the program administrator stated that the managers have discussed with the analysts the need to follow the licensing checklist to ensure that they meet

TABLE 3

Principal Licensing Requirements for Community Care Programs We Reviewed

Requirement	Foster Care			Adult Care		Senior Care
	Group Home	Foster Family Home	Foster Family Agency	Day	Residential	Residential
Applicants must meet the following licensing requirements:						
Attend orientation	✓	✓	✓	✓	✓	✓
Provide health screening document	✓	✓	✓	✓	✓	✓
Provide plan of operation	✓	*	✓	✓	✓	✓
Submit fingerprints for criminal record clearance†	✓	✓	✓	✓	✓	✓
Provide child abuse central index check	✓	✓	✓	—	—	—
Provide fire clearance document	✓	‡	—	✓	✓	✓
Provide disaster and mass casualty plan	✓	*	—	✓	✓	✓
Provide administrator certification document	✓	—	—	—	✓	✓
The department is required to do the following:						
Review application for all requirements	✓	✓	✓	✓	✓	✓
Review criminal history records*	✓	✓	✓	✓	✓	✓
Conduct prelicensing visit	✓	✓	✓	✓	✓	✓

Sources: Department of Social Services' evaluator manual and California's Health and Safety Code.

* Plan of operation and disaster and mass casualty plan are no longer required for foster family homes effective July 1, 2002.

† The department receives criminal history information from both the state Department of Justice and the Federal Bureau of Investigation.

‡ Not required for foster family homes providing care for six or fewer ambulatory children and/or children two years of age or younger.

— Not required.

all the necessary requirements. By licensing individuals before it obtains all the required information, the department may be licensing individuals unfit to care for vulnerable clients.

The department is moving toward having application specialists review all applications within each community care program. According to various program representatives, the senior care program has been using application specialists since October 2001, and the foster care program implemented this practice statewide in April 2003. Although our review of the senior care program's application process revealed fewer missing

required materials compared with the foster and adult care programs, centralizing application processing with one or two specialists may not eliminate all the department's weaknesses. We recognize that using specialists to process applications may improve the use of staff resources, make the application review process more consistent, and allow the programs to review application material more quickly. However, the department does not review its specialists' licensing decisions and, as our review of the senior care program revealed, even with greater familiarity of licensing requirements, application specialists do not always properly process applications.

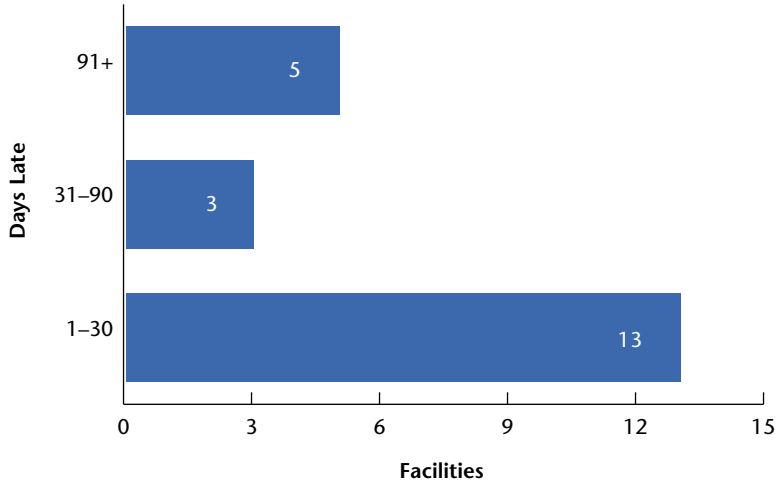
The Department Did Not Always Perform Required Post-licensing Visits

Not more than 90 days after it issues a license, the department must inspect each facility, except foster family homes, which are exempt from this requirement. Known as a post-licensing visit, the inspection is designed to evaluate a facility's compliance with rules and regulations and to assess a facility's continuing ability to meet regulatory requirements. Of the 54 licenses we reviewed, 44 required post-licensing visits. For 13 of these facilities, the department could not provide documentation that it had conducted the necessary post-licensing visits. Moreover, the department conducted post-licensing visits late for an additional 21 facilities. Figure 5 illustrates the length of time the department took to conduct the post-licensing visits beyond the required 90 days. Most of these visits were only minimally late, missing the deadline by 30 days or less. However, in one case, the department visited a group home 317 days past the 90-day requirement. As a result, more than one year passed since the date the facility received its license before the department could ensure that the home was operating in compliance with necessary regulations. In three of the five cases in which the department conducted post-licensing visits 90 days or more beyond the required time frame, the department found no deficiencies, and the other two had relatively minor deficiencies. Licensing regulations can often be complex, especially for inexperienced facility license holders (licensees), and the department's failure to promptly evaluate newly licensed facilities increases the potential for deficiencies to develop and persist. According to the program administrator for foster care, budgetary constraints have limited the department's resources. As a result, the department has focused its priorities on other areas as outlined in a department memorandum dated October 7, 2002. We are aware of the department's

memorandum and its focus; however, only two of the visits performed late were due after the October memo. Thus, we would have expected the department to fulfill its requirement to make its post-licensing visits promptly.

FIGURE 5

Number of Facilities We Reviewed for Which the Department Conducted Late Post-licensing Visits



THE DEPARTMENT DID NOT PERFORM ANNUAL FACILITY EVALUATIONS AS REQUIRED BY LAW

In our child care report, we disclosed that the department did not always complete child care facility evaluations as required by law. At that time the department responded that staff vacancies and unpredictable workload surges directly affect its ability to complete evaluation visits, but it would instruct its licensing offices to emphasize the importance of completing all facility evaluations within required time frames. During this audit, we found conditions similar to those reported for the child care audit. Specifically, the department did not perform evaluations for some community care facilities.

In a memorandum dated October 2002, the deputy director of the licensing division stated that the department was placing facility visits lower on its priority list and began allowing staff to defer visits to facilities meeting certain criteria. The deputy director explained that the department took this action because it had been unsuccessful in getting an exemption from the State's hiring freeze and retaining vacant positions. As a

result, the department decided to focus its efforts on higher-priority activities that provide the most protection for clients in community care facilities, with investigating complaints its primary focus. Although we recognize the department's dilemma, its policy for deferring visits is contrary to statute, which requires it to conduct annual evaluations for most types of facilities. Therefore, we question the appropriateness of deferring facility visits, which serve as an important means of ensuring that community care facilities are complying with licensing rules and regulations, thereby protecting the health and welfare of clients in care. Finally, because child care homes are on a three-year evaluation cycle rather than an annual one, if the department defers evaluations, these facilities may go without an evaluation for a total of six years. Currently, the department's database system is set up so that when it defers a visit to a facility, the visit will not appear on an analyst's visit-due list again until the next cycle for that facility type. According to the child care program administrator, the department has discussed the advantages of deferring visits to child care centers—which are on an annual review cycle—rather than child care homes when the option exists, but the department has yet to issue instructions regarding this practice.

Criteria for Deferring Facility Visits

The facility must have the following:

- An annual facility evaluation completed within the last 12 months.
- Fingerprint clearances for all applicable individuals, and for children's facilities, a child abuse central index check.

The facility must not have the following:

- Type A deficiencies—those that pose direct risk to the health and safety of clients—during the last 12 months.
- Civil penalties within the last 12 months.
- A noncompliance conference since the last annual visit or a compliance plan, and must not have been referred to the legal division for administrative review.
- A provisional or probationary license.

Evaluations of certain facilities, including foster family agencies, may not be deferred.

Because of the department's change of policy, we reviewed its facility evaluations in two periods: In the first period, the department was scheduled to perform 24 evaluations we reviewed after issuance of the October 2002 memorandum; therefore, the evaluations were subject to the department's deferral policy. The second period included 31 evaluations the department was required to perform between January 2001 and October 2002. The results from both test groups showed that the department was not performing evaluations as required and therefore did not always ensure the safety of clients in community care facilities.

Although the deputy director established guidelines for deferring visits in his October 2002 memorandum, the licensing staff did not always follow the guidelines. For example, of the 24 facilities due for evaluation after the October 2002 memorandum was issued, the department chose to defer seven facility visits; however, we found only one case in which

the analyst assessed and documented the facility's history as required. Because the department has implemented a policy that is intended to reduce the number of facility visits it is required to make under statute, and licensing staff are not properly employing the guidelines the department developed, community care facilities requiring additional monitoring may be overlooked, and clients in their care might be left in unhealthy environments.

Of the 31 facilities for which evaluations were due before the department announced its deferral policy, the department failed to perform 19 visits. In fact, our sample included two foster family agencies the department had failed to evaluate as required since at least 1999, more than four years before. In addition, we identified three facilities the department had not annually evaluated since issuing their licenses at least 18 months prior—two in 2000 and one in 2001.

THE DEPARTMENT DOES NOT PERFORM ALL THE CHILD CARE HOME FACILITY EVALUATIONS MANDATED BY LAW

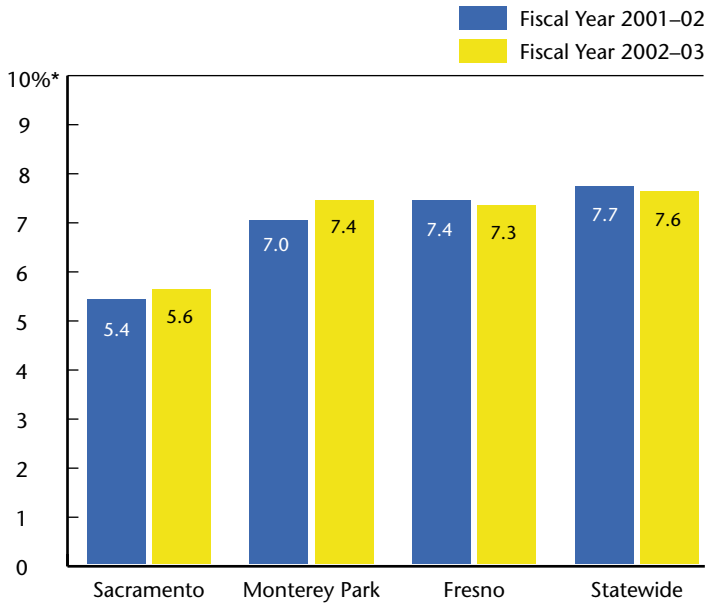
In the child care report, we stated that the department did not conduct the statutorily required annual evaluations of 10 percent of all child care homes and did not track its compliance with the requirement until February 2000. In response to our recommendation, the department reported that it would continue to track the number of evaluations and, to the extent possible, meet this requirement. Nevertheless, the department did not do so for fiscal years 2001–02 and 2002–03. The department also did not track whether it was meeting the requirement for conducting these annual evaluations. Because regular evaluations of child care homes are conducted on a three-year cycle, these additional annual visits provide supplementary assurance that the homes are operating in accordance with requirements during the interim periods.

State law requires the department to evaluate 10 percent of all licensed child care homes annually, in addition to completing other types of required visits, such as complaint investigations. We reviewed three child care licensing offices and, as shown in Figure 6 on the following page, none of the three met the 10 percent requirement in fiscal year 2001–02. Because the department did not meet its mandate to visit 10 percent of all

child care homes, and typically the department visits these homes only once every three years, the department ran a greater risk of not identifying when a home was operating in violation of licensing laws and endangering children.

FIGURE 6

Percent of Additional Child Care Homes Evaluated Annually in Three Licensing Offices and Statewide



Source: Bureau of State Audits compiled data based on the department's day care work volume reports.

* State law requires the department to evaluate 10 percent of child care homes annually.

Additionally, we found that although the department is capable of tracking the information, it has not developed a specific system to determine its compliance in this area. Without tracking this information on a consistent basis, the department cannot be aware of when it falls short of the law and therefore cannot make adjustments to ensure that it is meeting the requirement. According to the child care program administrator, when staffing is low and the department is not meeting the 10 percent requirement, the department instructs staff to focus on performing higher-priority activities, such as complaint investigations, rather than on conducting more visits.

THE DEPARTMENT DID NOT ALWAYS EVALUATE STAFF PERFORMANCE OR PROVIDE REQUIRED STAFF TRAINING

Analysts are the staff who carry out most licensing functions such as assessing license applications, investigating complaints, and conducting annual facility evaluations. However, the department has not ensured that supervisors in the senior care and adult care programs periodically review the quality of analysts' work. Further, the department has not determined that analysts for the senior care, adult care, and foster care programs meet all the training requirements the Health and Safety Code sets out. As a result of the department's limited staff oversight and training, it cannot be assured that analysts are appropriately trained and effectively administering the programs.

Supervisors in the Adult Care and Senior Care Programs Did Not Always Review the Quality of Analysts' Work

To periodically monitor the quality of the most important aspects of an analyst's work, the department created its quality enhancement process (QEP) reviews. Although supervisors in the foster care program prepared and documented the necessary QEPs for the analysts we selected to review, supervisors in the adult and senior care programs at the licensing offices we visited did not. This is a problem that we also noted in our child care report. In response to our recommendation in that audit, the department updated its programs' policies requiring supervisors to complete analysts' QEPs, but the adult care and senior care program supervisors did not follow these policies. A periodic review system is important because the department gives analysts a significant degree of autonomy over such functions as approving license applications, investigating complaints, and evaluating facilities. By not always preparing analysts' QEPs, the department has less assurance that the analysts in the adult and senior care programs are effectively applying program policies, which are designed to promote the continued safety of clients in community care facilities.

Analysts are responsible for performing important and sometimes complicated functions, including assessing applications for facility licenses, investigating complaints, and periodically evaluating facilities. We believe ongoing assessment of the analysts' performance is essential to ensure the continued health and safety of clients in community care facilities. Each analyst reports to a supervisor, who is responsible for staff assessments. In an effort to improve the quality and consistency of analysts' work, the department established its QEP, a means

for supervisors annually to assess analysts' work, such as processing license applications and investigating complaints, and to give them written and oral feedback. The department's most recent QEP document includes 10 required review sections and one optional section. Supervisors must review analysts' performance in all 10 required sections within three years, by selecting four sections covering each 12-month period. Each review is to cover the work within the previous six months.

QEP Review Sections

1. Application Process: Reviews three applications the analyst assessed.
2. Complaint Investigation: Reviews three complaint investigations the analyst completed.
3. Duty Officer: Observes the analyst intaking complaints and reviews three written complaints.
4. Group Orientation: Observes the analyst facilitating an orientation for potential caregivers.
5. Plan of Correction: Reviews three plans of correction from identification to resolution of facilities' deficiencies.
6. Enforcement Action: Reviews three of the analyst's legal cases.
7. Facility Evaluation Visit: Observes the analyst on two on-site visits.
8. Waiver or Exception: Reviews two of the analyst's recommendations on requests for waivers or exceptions, which are variances to specific regulations.
9. Work Practices/Workload Control: Reviews the analyst's administrative forms and work control documents.
10. Customer Service: Observes the analyst interacting with caregivers, clients, and department staff.

Optional Review Section

Annual and Triennial Licensing Evaluation: Reviews adequacy and documentation of facility review visits.

Source: Department of Social Services, Quality Enhancement Process, April 2003.

In our child care report, we found that the program supervisors were not preparing QEPs consistently, even though program supervisors admitted that daily job oversight became less frequent as an analyst's level of expertise increased, generally within three to six months. Consequently, the department re-emphasized the importance of QEPs to its supervisors and required them to submit QEP summaries to their managers to track the completion of QEPs. Additionally, the department changed its policy to require supervisors to explain to their managers why they had not completed QEPs.

Despite the importance of the QEP and the changes the department made to its policies, only supervisors for the foster care program completed the required QEPs for the analysts we selected for testing. Supervisors in the department's adult care and senior care programs generally did not complete QEPs for the analysts we selected. In fact, adult and senior care program supervisors did not complete nine of the 11 QEP reviews of analysts we selected for examination. Although the supervisor recalls preparing QEPs for the remaining two staff, she could not provide documentation to support her assertion.

Supervisors told us that in addition to QEPs, they use other methods to oversee analysts' performance and provided us with the guidebook that details steps supervisors should use to monitor workload, such as maintaining logs to document an analyst's progress on investigating complaints. Supervisors also indicated that they are always available to consult with analysts in unique situations. Although we agree that caseload management helps

to ensure work is completed promptly, we question whether it would guarantee quality work or consistently identify problems. Further, the department created the QEP as its method to monitor work quality. The department's instructions to supervisors do not indicate that supervisors may use other methods as a substitute for the QEP.

Most Staff Did Not Meet Training Requirements

The Health and Safety Code sets out staff development and training requirements for all analysts so they have the skills necessary to properly carry out their duties. We would expect the department to make available the necessary training and to have a method to track whether analysts are meeting statutory requirements. However, the department did not make sure that all analysts meet both the initial and continued training requirements, and it did not effectively track analysts' training. Within the first six months of employment, analysts must complete comprehensive training that covers areas such as conducting facility visits, human relations skills, investigation processes, and administration of regulations. New senior care staff who have earned fewer than 16 semester units in gerontology or geriatric education from an accredited college must also complete 40 hours of preservice gerontology training. Although three new analysts whose records we reviewed attended a comprehensive training academy, one did not receive the required additional gerontology training. The department states that it did not provide the gerontology training because it lacked the resources necessary to pay its training vendor, but that it is currently developing an in-house gerontology seminar. Until the department develops its seminar, a new analyst in the senior care program may not receive the required training or develop the understanding necessary to ensure that caregivers are providing basic needs to elderly clients.

The department also must ensure staff receive 36 hours of continued training annually. The Health and Safety Code specifies that the training must reflect the needs of community care facility clients, such as instruction covering the needs of foster children, people with mental disorders, or those with developmental or physical disabilities. Although these requirements are designed to provide information analysts need to stay current with the demands of their jobs, of the 22 analysts we selected who required this level of training during fiscal year 2001–02, 20 had training hours that fell short of statutory requirements. As shown in Table 4 on the following page, most

analysts had fewer than half the required hours of training. During the first half of fiscal year 2002–03 a majority of the analysts whose training records we reviewed also had fewer than half of the total required amount and several analysts had not received any training.

TABLE 4

Selected Analysts' Training Hours for Fiscal Year 2001–02 and Half of Fiscal Year 2002–03

	Number of Analysts	
Range of Training Hours	July 2001–June 2002	July 2002–December 2002
0	3	6
1-17	13	12
18-35	4	5
36 or more	2	2
Totals	**22**	**25***

* Includes three additional analysts who were new during fiscal year 2001–02 and were subject to the annual training requirements during fiscal year 2002–03.

The senior care program administrator told us that the department decreased its training because of budget cutbacks. To compensate for the lack of contract training funds, according to the program administrator, the department attempted to meet its mandated training requirements in part through training opportunities offered through other agencies and groups. However, it is inappropriate for the department to reduce training to less than statutory requirements. Further, such training cutbacks were contrary to directives from the Department of Finance, which oversees the budget for the State's executive branch, and the department's directions, which specified budget cutbacks were to be limited to nonmandated and noncritical activities. Although we understand that budget cutbacks affect the department's ability to pay for certain training, considering that analysts may spend 50 percent of their time in the field without direct supervision, it is important that they possess the skills necessary to independently investigate complaints and identify and cite deficiencies. Without the necessary ongoing training, we question whether analysts are prepared to effectively perform their duties.

Regardless of the department's reasons for not making available to analysts the required training, it does not have an effective or consistent method of tracking whether analysts are meeting statutory training requirements. For example, when we asked the manager of the Central Training Section to verify the period in which it measures whether analysts are meeting the requirements—that is, whether it is on a state fiscal year or calendar year basis—he could not give us a definitive answer. Additionally, the senior care program requires licensing office supervisors to report training monthly, whereas the foster care program leaves it up to the analysts to track their own training and requests the information as needed. Consequently, the department cannot demonstrate that analysts meet training requirements, and it does not have information necessary to determine what training certain analysts need to perform their duties at the highest level.

RECOMMENDATIONS

To ensure that complaints are promptly and thoroughly investigated and that facilities correct deficiencies, the department should do the following:

- Continue to emphasize complaint investigations over other duties.
- Require analysts to begin investigating complaints within 10 days of receiving complaints and, whenever possible, to resolve investigations within 90 days.
- Ensure that analysts follow policies requiring them to refer to the investigations unit any serious allegation within eight hours of receipt and issue citations for serious allegations the investigations unit has substantiated within 10 days of receipt.
- Make sure that abuse allegations that are deemed inconclusive are reviewed with the legal division.
- Require supervisors to review evidence that facilities took corrective action before signing off on a complaint.

To make certain that certified foster parents correct identified inappropriate behaviors, the department should do the following:

- Require foster family agencies to ask each applicant whether he or she had uncorrected, substantiated complaints at any other foster family agency.

- Require foster family agencies to verify the accuracy of the applicant's statements with the applicant's immediate prior foster family agency.

To ensure that it issues licenses only to qualified individuals, the department should ensure that analysts follow the checklist in collecting and considering all required information before it grants applicants' licenses, including, but not limited to, health screening reports, administrators' certifications, and necessary background checks.

The department should also conduct the necessary post-licensing evaluations within the required time frame to make certain that newly licensed caregivers are operating in compliance with the regulations.

If the department plans to continue to defer required facility evaluations, it should do the following:

- Seek legislative approval for its deferral plans.

- Ensure staff understand the guidance on visits that qualify for deferral and that staff are properly implementing the deferral policy.

- Modify its licensing information system so that when it defers a visit to a child care home, the visit would be deferred for one year—similar to other facility types—as compared to a full three years.

Because it receives supplementary assurance through selected annual visits that child care homes are operating in accordance with licensing requirements between triennial visits, the department should:

- Track its compliance with and meet the requirement that 10 percent of all child care homes be visited annually.

- If the department determines it cannot meet the 10 percent requirement, work with the Legislature to modify the law or develop a plan to fulfill the requirement.

To ensure that analysts are adequately supervised and trained, the department should do the following:

- Make certain that all licensing office supervisors are conducting complete and prompt quality enhancement process reviews of their assigned analysts.

- Make available to analysts the necessary training and develop a method to track whether analysts are meeting statutory training requirements. ■

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CHAPTER 3

The Department of Social Services Should Follow Up on Counties' Performance More Diligently, but Fresno and Kern Counties Generally Administered Their Programs Effectively Except for Complaint Processing

CHAPTER SUMMARY

The Department of Social Services (department) contracts with 42 counties to license foster family homes. Each county must license and monitor foster family homes within the county in accordance with state laws and regulations as well as department policies. The department is then responsible for monitoring the counties' compliance with the requirements. Although the department performs reviews of counties that license foster family homes, it does not adequately guide the staff doing the reviews. Consequently, the counties do not always promptly correct identified deficiencies, which diminishes the effectiveness of the department's reviews. Further, the department lacks procedures to review and assess the counties' reports on criminal history exemptions. As a result, the department has less assurance that all counties are licensing foster family homes correctly and granting criminal history exemptions according to department policy. Nevertheless, Fresno and Kern counties were generally in compliance with requirements when carrying out their licensing and evaluation functions. However, Kern County did not always follow up to ensure foster family homes corrected the deficiencies it identified while investigating complaints, and both counties sometimes failed to consult with the department's legal staff when the counties could not determine the validity of an abuse allegation when investigating complaints. By not effectively ensuring that all counties fulfill all their responsibilities in licensing and monitoring foster family homes, the department potentially puts children's welfare at risk.

THE DEPARTMENT HAS ADEQUATELY MONITORED COUNTY LICENSING FUNCTIONS BUT DID NOT ALWAYS ENSURE COUNTIES PROMPTLY CORRECTED DEFICIENCIES

As the department's agents for licensing and monitoring foster family homes within their geographical boundaries, contracted counties must follow related state law and department guidelines for implementing and enforcing rules and regulations pertaining to foster family homes. As of February 2003, 42 counties had licensed and were monitoring more than 8,100 foster family homes statewide (see Table 2 on page 13). Although the department reviews the counties' licensing programs, it provides limited guidance regarding time frames to department staff performing the reviews, which has contributed to counties delaying their corrections of deficiencies. To each county, the department assigns a liaison who is responsible for providing the county with training and guidance as well as reviewing the county's licensing program. According to the acting liaison manager, a liaison is also responsible for reviewing each county every two years, in most cases, or more frequently if the county has noncompliance issues. When reviewing a county's licensing program, the liaison visits the county's licensing office and evaluates activities, using an assessment plan the department developed, that we believe appropriately identifies important areas for review. The plan covers 14 areas of inquiry, such as processing license applications, conducting criminal history checks, and investigating complaints. Depending on what the liaison finds, the department can make recommendations to improve a county's licensing program or to bring the program into compliance with laws and regulations.

Although the department provides guidelines to the liaisons performing reviews, it does not give liaisons clear time frames for preparing their reports, notifying counties about deficiencies, and requiring counties to correct deficiencies. To ensure that liaisons treat all counties consistently and that counties correct deficiencies promptly, we would expect the department to have policies guiding liaisons in these areas, but it does not. When we asked the program administrator why the department did not establish time frames for liaisons to prepare county review reports, brief the counties on the review findings, or for counties to develop corrective action plans, she said that completion of the final program review is a priority. She told us liaisons are expected to submit a draft of the report to the foster care program office for approval within 10 days. However, because of daily program emergencies and other priorities, the liaisons may extend the 10-day period. Our analysis shows that

liaisons do not always meet these expectations. She also told us that counties usually must submit their corrective action plans between 14 and 60 days, depending on the seriousness of the issues. However, as shown in Table 5, four of the counties we reviewed submitted corrective action plans far beyond even the longest time she expects.

We evaluated the department's most recent reviews of Fresno, Kern, Kings, Orange, San Bernardino, San Diego, and Santa Clara counties. The Joint Legislative Audit Committee specifically selected the first three counties for the audit, and we selected the remaining four based on the number of children in foster care in the county. Our analysis revealed that liaisons sometimes allowed a long time to elapse between the end of their reviews and the due date for the counties to submit their corrective action plans. Four counties we reviewed originally had between 120 days and 329 days after the end of the review to submit their plans, and the liaison granted extensions to the due dates for three of these so that they had even more time to respond. In addition, one liaison contributed to a county's delayed corrective action by taking four months to have a final meeting with the county to discuss its deficiencies. Table 5 also shows the length of time, including time for extensions, liaisons allowed counties to take to submit their corrective action plans as well as the number of areas in which the counties needed to improve.

TABLE 5

Number of Days the Department Allowed Counties to Submit Corrective Action Plans and the Number of Areas the Department Identified as Deficient

County	Last Day of Department's Review	Date County Submitted Corrective Action Plan	Days Between Last Day of Review and County's Submission of Corrective Action Plan	Number of Areas With Identified Deficiencies
Fresno	March 20, 2002	May 7, 2002	48	1
Kern	May 22, 2002	July 11, 2002	50	10
Kings	June 27, 2002	August 9, 2002	43	5
Orange	December 31, 2002*	June 18, 2003	169	8
San Bernardino	March 8, 2002	May 23, 2003	441	8
San Diego	October 6, 2002	July 22, 2003	289	9
Santa Clara	October 23, 2001	April 26, 2002	185	2

* Specific date not listed, assumed conservatively last day of the month.

The longest delay occurred in San Bernardino County. After giving the county almost a year to develop a plan to correct deficiencies the department identified in March 2002, the department granted San Bernardino County a 112-day extension to submit its plan to correct deficiencies in how it processes applications and criminal record clearances and how it evaluates foster family homes. According to the county's liaison, the county was going through a management change; thus, we think it is reasonable for the department to allow some additional time. However, a year seems unreasonable, particularly considering the nature of the deficiencies, because problems may persist between the time the liaison completes the review and the time the county develops a plan to correct the deficiencies. Again, when we asked the program administrator for the foster care program if the department has a policy for granting counties extensions for developing corrective action plans, she stated that specific time frames for counties to submit their corrective action plans are established on a county-by-county basis. Similarly, she stated requests for extensions of time are either approved or disapproved based on the severity of the deficiencies and the reasonableness of the counties' requests. We believe that this flexibility may have contributed to the delayed corrective action for the counties we described above. By not obtaining the counties' evidence of prompt corrective action, the department has limited the effectiveness of its county reviews and potentially allows counties to continue to operate improperly.

DESPITE RECENT EFFORTS TO IMPROVE, THE DEPARTMENT COULD DO MORE TO OVERSEE COUNTY CRIMINAL HISTORY EXEMPTIONS

Similar to the department, the counties that contract with the department to license foster family homes also perform background checks on potential caregivers and nonclient residents to ensure that people with serious criminal histories are not providing foster care or living in foster family homes. The department has not consistently enforced a requirement that helps with its oversight of counties' performance in granting criminal history exemptions. In its evaluator manual—which contains the policies and procedures the department's staff and the counties must follow—the department states that contracted counties must submit exemption reports each quarter. The reports must detail each exemption a county grants or denies based on the background checks it performs. However, the department did not fully utilize the reports and

stopped requiring counties to submit them. Because it did not have the reports, the department could not track the criminal history exemptions the counties granted or make certain it was completely informed of counties' exemption processing.

Although the department now collects counties' criminal history exemption reports, it lacks procedures for reviewing and following up on the data.

In July 2002, the department notified contracted counties that they were once again to submit exemption reports, beginning in October 2002. Although the department now collects the reports, it lacks adequate procedures for reviewing these data and identifying cases for follow-up and necessary corrective action. The department has general procedures stating that it will review and follow up on the reports, but the procedures lack specific evaluation standards and timelines. We would expect the department to implement a sound and thorough review process that would instruct staff when to review the counties' exemption reports, what to look for in them, and when to follow up on reported decisions. However, the department does not provide its staff guidance on when to review the reports, what to look for when they perform their reviews, and when to follow up. As a result, although the department collected three reports covering July 2002 through March 2003, and a department manager stated that staff began their review in October 2002, staff did not begin follow-up on the reports until we began our own review and inquired in April 2003 about the status of the reports. At that time, the department had allowed six months to elapse before it identified exemption decisions for which it needed more information. The exemption reports supplement the county liaisons' reviews of exemptions during their broad periodic county reviews. We believe these broad reviews are valuable and provide opportunity for a more thorough review of individual exemptions. Whereas we noted only minor issues in our review of Fresno and Kern counties' exemptions, collecting and reviewing the exemption reports on a continuous basis allows the department to track criminal record information from all 42 counties and makes certain it is aware of all their exemption processing.

FRESNO AND KERN COUNTIES DID NOT ALWAYS FOLLOW REQUIRED COMPLAINT PROCEDURES

The department directs all contracted counties to follow its complaint procedures to ensure the adequacy of investigations, yet Fresno and Kern counties did not always follow these procedures. Further, the supervisors reviewed and signed off on the complaints but sometimes failed to discover these

deviations. By not completely investigating complaints and making certain that foster family homes correct their deficiencies, the counties may allow foster family homes to continue to provide inferior care to children.

Counties investigate complaints to identify and correct potentially unsafe or unhealthy foster family homes. When investigating complaints, counties must follow the department's process, which includes requiring noncompliant foster parents to develop corrective action plans. Counties investigate complaints to bring foster family homes into compliance with laws and regulations, and the department requires a corrective action plan to specify how the foster parent will address each deficiency. However, after reviewing five complaints requiring corrective action plans, we found three cases in which Kern County did not establish adequate corrective actions with caregivers. For example, Kern County received a complaint with numerous allegations, including one that a foster parent disciplined one child in the foster home by hitting him with a thorny stick. Corporal punishment is not allowed in community care facilities. After conducting an investigation, the analyst confirmed that the foster parent was abusive. We believe that the analyst could have required the foster parent to attend training on properly disciplining a child or sought legal action from the department to revoke the foster family home license and that these requirements would have more effectively addressed the complaint. However, the analyst chose to reduce the foster parent's care capacity from five to two children ages 10 and above and placed the home on probation for three months. Moreover, the analyst did not perform additional follow-up to determine that the foster parent corrected past behaviors. After we brought the issue to its attention, the county took steps to address the caregiver's licensing violations. The county is now working with the department's legal division to determine appropriate action against the foster family home.

Kern County did not always establish adequate corrective action with caregivers.

In addition, in Kern County, but not Fresno County, analysts twice accepted foster parents' promises to comply with regulations as corrective action plans. For example, one analyst accepted a foster parent's promise never again to leave a foster child in the home unattended. Because the county specifically identified this case as posing an immediate risk to the child in care, Kern County violated the department's policy by accepting a self-certification, which is appropriate to accept only when a deficiency represents a potential, rather than an immediate, risk to a client. The analyst's supervisor reviewed the complaint but

did not correct the analyst's departure from department policy. Moreover, given that a foster parent's promise provides nothing of substance for an analyst to review for follow-up, the analyst did nothing more to ensure that the foster parent changed the care the foster child received.

To make sure that analysts consider all available information and arrive at appropriate conclusions on serious allegations such as physical or sexual abuse, counties must consult with the department's legal division (legal) on inconclusive resolutions. However, neither Fresno County nor Kern County always consulted with the department's attorneys on these inconclusive cases. For example, Kern County received a complaint alleging that a caregiver hit a foster child in the nose. After performing an investigation, the analyst deemed the allegation inconclusive and did nothing more. Considering the sensitivity of the allegation and that it is a department requirement, the analyst should have consulted with legal staff, who would further review the evidence and reach an independent conclusion on the allegation. We are also concerned because in three of 10 complaints we reviewed, Kern County misclassified corporal punishment as a personal rights violation. By misclassifying allegations as something other than abuse, analysts might not complete required procedures specific to serious abuse allegations, such as consulting the department's legal division, or might perform less comprehensive investigations, either of which could result in the potential victimization of children. In the incidents just described, the analysts' supervisor approved the closure of the complaint without consulting the department's legal division. The failure of Fresno and Kern counties to follow departmental procedures in investigating complaints and making sure corrections are made may leave some children in unsafe foster family homes.

FRESNO AND KERN COUNTIES GENERALLY LICENSED AND EVALUATED FOSTER FAMILY HOMES AND ENFORCED LEGAL DECISIONS AS REQUIRED

Based on the results of our review of Fresno and Kern counties for 2001 and 2002, the communication between the department and the counties was clear regarding the counties' obligations relative to foster family homes. In general, the two counties followed department guidelines when they processed license applications and made exemption decisions. Moreover, the counties annually visited and evaluated the foster family homes

that they licensed. Finally, the two counties appropriately enforced legal decisions. As a result, the department had greater assurance that these homes were safe and healthy environments for children.

Fresno and Kern counties appropriately processed the license applications for the 20 foster family home licenses we reviewed that the counties granted between January 2001 and December 2002. As specified in their contracts with the department allowing them to license foster family homes, counties must follow the department's guidelines for processing and approving foster family home applications. For each of the 20 applications we reviewed, the counties generally followed the department's guidelines with only minor, isolated deviations. For example, the counties held program orientations, reviewed criminal record clearances, and conducted the necessary visits before approving licenses for foster family homes.

Also, for the 14 cases occurring between January 2001 and December 2002 that we examined, Fresno and Kern counties made exemption decisions consistent with the department's procedures. We reviewed four exemptions that Fresno granted and 10 that Kern granted and found that both counties processed all applications in a manner consistent with the department's requirements, with only isolated, minor omissions. Further, when the counties received subsequent criminal record transcripts from the Department of Justice for individuals already working or residing in facilities, they appropriately followed the department's procedures for collecting information and making decisions whether to allow the individuals to remain in the facilities.

Fresno and Kern counties made exemption decisions in line with the department's procedures and generally evaluated foster family homes as required.

To ensure quality care, the Health and Safety Code requires the department and its agents, the counties, to visit and evaluate licensed community care facilities, including foster family homes, at least annually. From March 1, 2002, to March 1, 2003, Fresno and Kern counties generally met the annual visit requirement for the 10 foster family homes we reviewed in each of the two counties, although Kern County did five of the reviews between one and 59 days late. Moreover, the counties appeared to follow the department's guidelines for conducting their visits to foster family homes. For example, the counties cited homes for deficiencies and obtained adequate evidence of corrective actions when necessary.

The county offices we reviewed generally enforced appropriately the 10 legal actions we reviewed. Following the department's process, county offices must enforce legal decisions against facilities whose licenses the department has revoked or placed on probation or when it has excluded an individual. When the department revokes a facility license, it requires the responsible county office to visit the facility at least once within 90 days after the effective date of the revocation if the facility is known to be operating. For the seven revocation cases we reviewed that were decided in 2001 and 2002, the counties demonstrated sufficient knowledge that a facility was no longer operating after the department ordered its license revoked. However, in one probation case, Kern County did not conduct a facility visit within 90 days after the effective date of the probation as required and had yet to do so as of May 2003, two years later.

RECOMMENDATIONS

To help ensure that counties contracting with the department to license and monitor foster family homes adequately and promptly respond to complaints and enforce corrective actions, the department should establish a reasonable time frame for liaisons to prepare reports resulting from reviews of the counties and to notify counties about the results of those reviews. It should also establish a reasonable time frame in which all counties must submit and complete their corrective action plans. Finally, the department should create a reliable method for tracking county corrective actions to ensure they are not overlooked.

To help ensure that counties contracting with the department to license foster family homes are making reasonable decisions regarding criminal history exemptions, the department should develop procedures to ensure that it promptly and consistently reviews quarterly reports on exemptions granted by each contracted county.

To be certain they adequately investigate all complaints against foster family homes and ensure that deficiencies are corrected, the counties should follow current policy and any policy changes the department implements as a result of the recommendations in this report.

To ensure that a facility on probation complies with the terms of the probation, Kern County should abide by the department's procedures and make a compliance visit to the facility within 90 days following the legal decision. ■

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CHAPTER 4

The Department of Social Services Improved the Timeliness of Its Processing of Legal Actions, but Could Have Done More to Enforce the Resulting Decisions

CHAPTER SUMMARY

Although the Department of Social Services (department) appears to prioritize and quickly process cases involving legal actions against individuals who fail to comply with licensing laws and regulations, its enforcement of decisions and orders (decisions) is not always timely, consistent, or thorough. When necessary, the department can take legal action to revoke a facility license or bar individuals working or residing in a facility. Legal action helps ensure that anyone who will not or cannot comply with licensing laws and regulations does not care for or come in contact with clients in community care facilities. In our review of 43 cases in which the department took legal action, we found that the department's legal division generally prioritized cases to ensure that it filed accusations in a timely manner, often in significantly less time than its internal goal. However, once the department signed the decision, the licensing offices did not consistently or promptly follow up with the facility to enforce it.

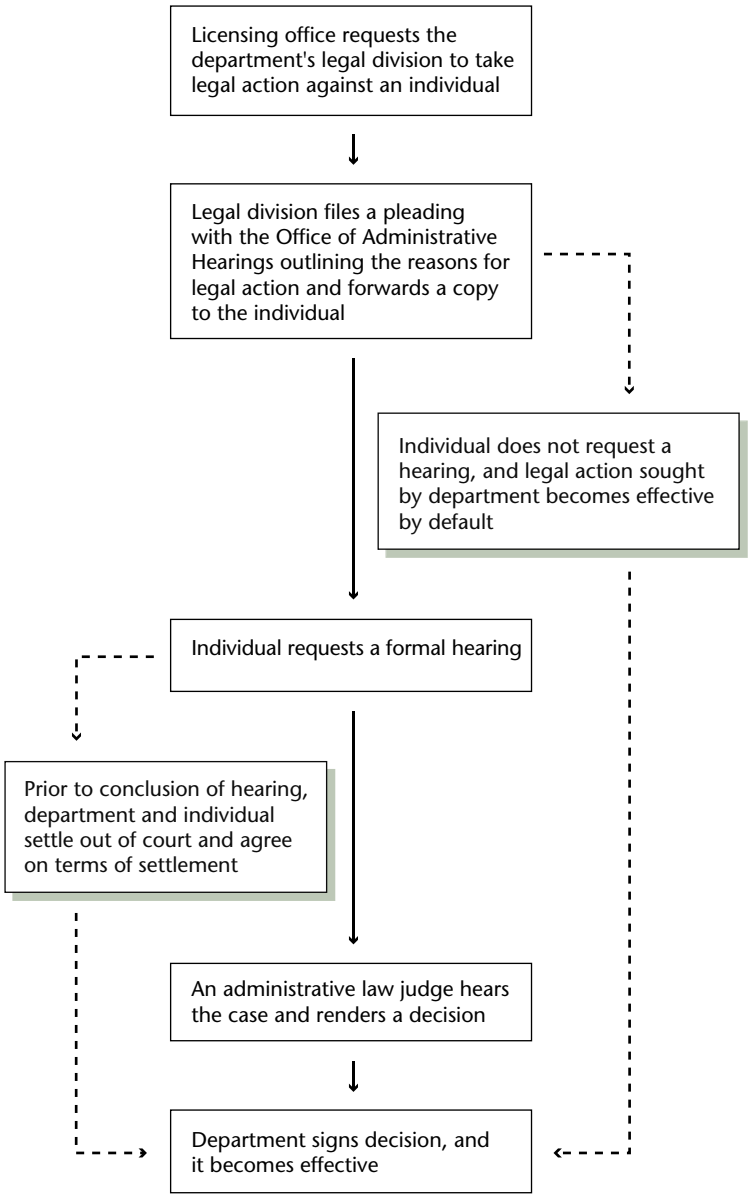
THE DEPARTMENT APPROPRIATELY PRIORITIZED LEGAL CASES WE REVIEWED AND ENSURED THAT THEY WERE PROCESSED QUICKLY

The department can take formal legal disciplinary action against a facility license holder (licensee), employee, or adult nonclient resident who repeatedly fails to comply with or seriously violates licensing laws or regulations or engages in criminal conduct. If the department is unable to achieve compliance, it refers the case to the department's legal division. The department's options are to suspend or revoke the facility license, exclude an employee or adult nonclient resident from a facility, or place the

licensee on probation. As Figure 7 illustrates, the department's legal action process is initiated by a licensing office and may involve either an administrative law judge deciding the case or the department and licensee negotiating a settlement.

FIGURE 7

The Department's Legal Action Process



The department can suspend or revoke a facility's license for the following reasons:

- The licensee violates or contributes to the violation of licensing rules and regulations.
- The licensee, employee, or non-client resident is convicted of a crime specified in statute.
- The licensee commits an act which is inimical to the health or safety of a client.
- A licensee or caregiver knowingly allows a child to possess illegal drugs or alcohol.
- The licensee engages in acts of financial malfeasance, including fraud or embezzlement.

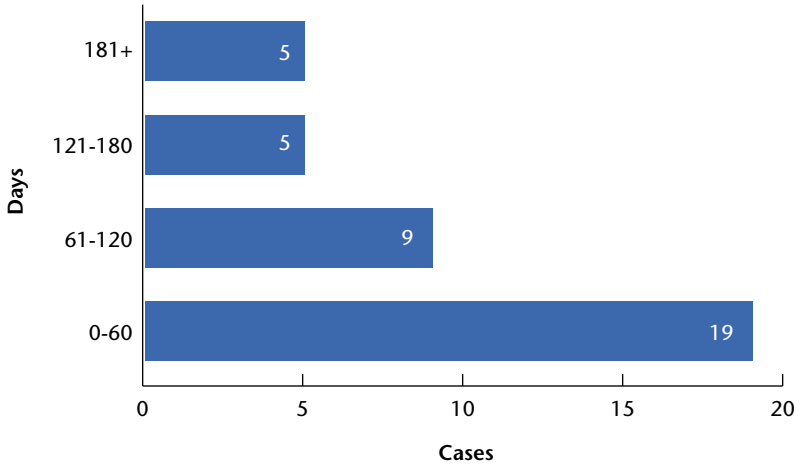
Once the department's legal division receives a request for legal action, its first step is to file a legal document, known as an accusation, with the Office of Administrative Hearings outlining the department's reasons for taking legal action. In April 1998, in an attempt to minimize delays in filing accusations, the legal division set a goal of six months for circulating accusations for management approval for all cases received. After the attorney circulates the accusation, the deputy director still must approve and sign it. The deputy director generally signed accusations within one month for the actions we reviewed.

Attorneys in the legal division are responsible for prioritizing cases they receive based on the information the licensing offices provide. The department gives its attorneys written guidance instructing them on the department's case-filing priorities. For instance, the department places the highest priority on serious allegations that appear to warrant immediate facility closure. For these cases, the department issues temporary suspension orders (TSOs). In addition, because of statutory requirements, the department places a high priority on any case in which the licensing office issued an immediate exclusion of a caregiver or nonclient resident and that person appealed the exclusion. In contrast, the department places a lower priority on cases that pose less risk to clients. For example, the department places its lowest priority on any case in which an individual who is not operating a facility appeals a denied application.

In our review of 43 appeals of exemption denials and legal actions from the four community care programs, we found that five were serious allegations wherein the department issued TSOs or immediate exclusions. The department circulated accusations for both TSO legal actions within one day of receiving them. In addition, the department complied with statutory requirements by circulating an accusation within 30 days in each of the three legal actions in which it had issued an immediate exclusion order and the individual appealed the order. The department also circulates its lower-priority legal actions quickly, often in much less time than its six-month goal. As Figure 8 on the following page shows, in 28 of the 38 lower-priority legal actions we reviewed, the department circulated accusations in four months (120 days) or less. Four of the five legal actions the department did not circulate within its six-month goal were filed against

FIGURE 8

Time the Department Took to Circulate Accusations for the Less Serious Cases We Reviewed



facilities or individuals not serving clients. The fifth involved an individual whose job did not involve contact with clients. Therefore, we see limited risk from the delays on these appeals.

To help it handle its caseload, in fiscal year 2001–02, the department received approval for and, according to its assistant general counsel, filled 12 staff positions—seven attorneys, two analysts, and three support staff—which have apparently helped it continue to meet its case-filing goal. In addition to receiving these positions, in November 2002, the department attempted to improve its efficiency by reorganizing its legal division along program lines. The legal division's assistant general counsel stated that the reorganization allows the attorneys to focus on one or two programs and relevant regulations and policies. Since it takes time to become familiar with a program's regulations and policies and any applicable changes, attorneys save time by focusing on one or two programs. Moreover, the assistant general counsel stated that reorganizing allows each attorney to develop relationships and resources within her or his assigned program and work with only one or two program administrators, again helping to streamline case resolution. The additional positions the department received, along with its efforts to improve efficiency through reorganization, should help it continue to efficiently and effectively file cases.

BY CONDUCTING FOLLOW-UP VISITS, THE DEPARTMENT COULD HAVE IMPROVED ITS ENFORCEMENT OF LEGAL ACTIONS

Once the department signs a decision revoking a caregiver's license, excluding a caregiver or adult nonclient resident, or putting a caregiver on probation, the legal division is responsible for sending a copy of the decision to the applicable licensing office. The licensing office is then responsible for enforcing the legal actions. In our review of 43 legal action files, although we found that the department sent almost all the decisions promptly to the licensing offices, the licensing offices did not always adequately enforce legal actions against licensed care facilities. In our audit of August 2000 titled *Department of Social Services: To Ensure Safe, Licensed Child Care Facilities, It Needs to More Diligently Assess Criminal Histories, Monitor Facilities, and Enforce Disciplinary Decisions* (child care report), we indicated that the department did not effectively ensure that all licensees placed on probation were complying with settlement terms and that it did not diligently enforce revocation and exclusion decisions. We attributed these weaknesses primarily to the department's failure to provide adequate guidance to its licensing offices. As a result, in February 2001, the department distributed revised policies and procedures for enforcing legal decisions. Nevertheless, in our current review, we found that licensing offices did not always adhere to these new policies and procedures.

We reviewed 26 legal actions, of which six resulted in probation for the licensees or employees. When the department places a facility on probation, it requires a licensing office to visit the facility within 90 days of the effective date of the legal decision. In five of the six probation cases, the licensing offices failed to visit the facilities within the required time frame to review the facilities' compliance with their probation terms. In two of these five cases, the licensing offices made their first visits that addressed probationary terms six months or more after the licensees' probationary periods started and cited the facilities for deficiencies in direct violation of their probations. Specifically, a facility received two complaints, both of which the licensing office found inconclusive. However, although this facility was on probation, the licensing office limited its review to the complaint allegations rather than also assessing the facility's compliance with its probation as part of the licensing office's complaint investigation. In fact, the licensing office did not assess the facility's compliance with its probation until nearly eight months after the facility's probation started. During

its annual visit, the licensing office cited the facility for two deficiencies requiring immediate action to avoid direct risk to the health and safety of its clients. According to the senior care program administrator, the licensing office did not receive the decision before it made the first complaint visit. In addition, he told us that a staff shortage played a role in the licensing office's inability to respond as appropriately as the department would have liked. However, the program administrator acknowledged that the analyst should have expanded the complaint investigations to review the facility's compliance with the probationary terms. He also acknowledged that it is more efficient for the department to fulfill multiple responsibilities during a facility visit and has discussed this with staff.

In two cases, licensing offices did not conduct subsequent visits to ensure excluded individuals were not present in licensed facilities.

Six of the 26 legal action cases we reviewed required the licensing offices to exclude individuals from licensed facilities. In two of the six cases, the licensing offices failed to conduct any subsequent visits. The department's legal decisions were effective March and July 2002 for the two facilities; however, the licensing offices have yet to visit these facilities, choosing to defer the 2002 annual evaluation in one case, but overlooking the other. As a result of the missed visits, the licensing offices could not verify that the individuals in these cases did not have access to the licensed facilities from which they were excluded. We asked the department to explain why these visits were not made. According to the program administrator for foster care, the licensing office inappropriately deferred the annual evaluation for the one facility and contended that, because the facility is in good standing, there was no reason to suspect the facility had not removed the excluded individual. In the other case, according to the senior care program administrator, on July 8, 2003, the licensing office visited the facility and verified that the excluded individual was no longer associated with that facility. The program administrator acknowledged that the licensing office made this visit because of our inquiry. In addition, the visit revealed two other licensing violations.

Finally, two licensing offices could not demonstrate their follow-up activities in three revocation cases and one exclusion case we reviewed because they did not document their actions. When the department revokes a facility license, it requires the responsible licensing office to visit the facility at least once within 90 days after the effective date of the legal decision if the facility is known to still be operating. Because the department does not require follow-up of revocation cases in which they know facilities are not operating, it is critical for the licensing

offices to document how they determined that the facilities were no longer operating and therefore required no additional follow-up. Similarly, in exclusion cases, the licensing offices' documentation of their monitoring activities is important to provide evidence that excluded individuals are no longer associated with facilities.

RECOMMENDATION

The department should conduct follow-up visits to ensure that enforcement actions against facilities are carried out. The department should also document its follow-up for enforcement of revocation and exclusion cases.

We conducted this review under the authority vested in the California State Auditor by Section 8543 et seq. of the California Government Code and according to generally accepted government auditing standards. We limited our review to those areas specified in the audit scope section of this report.

Respectfully submitted,

ELAINE M. HOWLE
State Auditor

Date: August 19, 2003

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APPENDIX A

Summary of the Recommendations From Our August 2000 Audit of the Department of Social Services

The Joint Legislative Audit Committee requested that we evaluate the effectiveness of the corrective actions of the Department of Social Services (department) and the Department of Justice (Justice) in response to our August 2000 audit, *Department of Social Services: To Ensure Safe, Licensed Child Care Facilities, It Needs to More Diligently Assess Criminal Histories, Monitor Facilities, and Enforce Disciplinary Decisions* (child care report). As we noted previously, since the department uses the same licensing, monitoring, and legal procedures for the programs reviewed in the current report, many of the recommendations we made in the child care report also apply to the foster care, adult care, and senior care programs. Table A.1 summarizes our previous recommendations, the department's and Justice's one-year responses, and the results of our current review.

TABLE A.1

Recommendations From Our August 2000 Audit, Responses, and Follow-Ups

Child Care Audit Recommendation (August 2000)	One-Year Response (August 2001)	Bureau of State Audits' Follow-Up
Legislature		
To protect children in licensed child care facilities, the Legislature should do the following:		
• Assess the department's level of discretion to exempt individuals with criminal histories and determine whether that level is appropriate. • Consider pursuing laws to automatically deny an exemption on a greater range of crimes and expand the variety of serious arrests the department may review during its exemption process.	In September 2000, the governor signed Senate Bill 1992 (Chapter 819, Statutes of 2000). This bill, among other things, expanded the list of crimes for which the department cannot grant an exemption and added crimes to the serious arrest list.	Since the child care audit, the department has implemented policies and procedures with stricter exemption criteria. However, the department still granted questionable criminal history exemptions and did not always consider important an applicant's lack of honesty when filing for an exemption.

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Child Care Audit Recommendation (August 2000)	One-Year Response (August 2001)	Bureau of State Audits' Follow-Up
• Clarify existing requirements to specify whether an individual can have contact with children, pending a Federal Bureau of Investigation (FBI) check.		We are unaware of any legislative action taken to implement this recommendation.
Department of Social Services		
The department should implement the FBI record-checking requirement, re-evaluate its current FBI records review policies and procedures, and properly apply the requirements that allow individuals to work with or be in close proximity to children while their FBI check is pending.	The department noted that it reviewed its FBI check processes and found them to be in accordance with the law. It also stated that in April 2001, Justice began sending FBI-check information to the department electronically.	The department's interpretation of the FBI background check requirement differs from ours, and the department's interpretation does not fully protect children. We believe the law states that the department cannot authorize any individual who discloses criminal convictions to begin caring for children until an FBI check is complete. However, the department interprets the law to authorize it to allow people who disclose criminal convictions to begin caring for children before going through the mandatory FBI check.
To ensure criminal history exemptions are not granted to individuals who may pose a threat to children, the department should do the following:		
• Follow its new procedures that require management to review all criminal exemptions involving felonies and require management to periodically approve a sample of all other exemptions granted.	The department indicated that it requires supervisory review of all felony exemption cases and that supervisors are reviewing 10 percent of all other exemption requests.	Quality control measures were sometimes ineffective and inconsistent when the department reviewed a sample of exemption decisions, including decisions granting exemptions to convicted felons. The exemption manager told us that the quality control process did not review a representative sample, but instead focused on cases processed by new analysts or analysts with performance problems. Therefore, this review would not detect poor decisions made by more experienced analysts.
• Actively consider all available information, not just criminal record transcripts (rap sheets) when granting exemptions.	Staff are actively considering all available information, not just rap sheets, when deciding on an exemption request.	The department still did not sufficiently consider information other than convictions when reviewing five of the 45 approvals we examined, despite its policy to approve or deny an exemption based on a comprehensive review of all available information. In addition, the department accepted without question character references that appeared inadequate.

Child Care Audit Recommendation (August 2000)	One-Year Response (August 2001)	Bureau of State Audits' Follow-Up
To process criminal history checks as quickly as possible, the department should do the following:		
• Establish and meet its goal for notifying individuals that an exemption is needed, develop safeguards to help ensure that municipal agencies provide information promptly, and use its tracking system to identify cases that are not progressing to a reasonable, timely conclusion.	The department began piloting an automated case management system in December 2000 to assist staff in tracking background check activities. In addition, it stated that it has no jurisdiction over municipal agencies and changes would require legislative action. The department reported that a legislative attempt (Assembly Bill 1447, Granlund) to require child protective agencies to maintain child abuse reports in a location and manner that would make them easily retrievable did not pass.	In more than 80 percent of the cases we examined—versus the 20 percent we previously reported—the department failed to notify the appropriate facilities or individuals within at most 15 days of receiving rap sheets from Justice that criminal history exemptions were needed. Department managers explained that these delays resulted from the department's installing of a new database application. However, we still saw evidence of delays that were unrelated to the installation of a new database. The department also had difficulty issuing exemption decisions on time. The department's emergency regulations took effect prohibiting an individual's presence in a licensed facility before obtaining a criminal history clearance or an exemption. As a result, the department must ensure it processes the necessary criminal history reviews quickly, so as not to impede an individual's right to work or a facility's ability to operate.
The department, with the Legislature, should require disclosure of criminal history exemptions and determine the types of criminal histories and lengths of time this requirement should apply to.	The governor vetoed Assembly Bill 2431, which would have added a provision to the Health and Safety Code allowing the public to view documents the department sent to a facility license holder (licensee) regarding criminal background check exemptions. The department, along with Justice, determined that making criminal history exemptions public information would violate an individual's right to privacy. It is currently litigating a Public Records Act request regarding past criminal history exemptions it has granted.	In 2001, the courts ordered the department to disclose criminal history exemptions. In August 2002, the department implemented emergency regulations requiring child care facilities to inform parents of their right to inquire as to the name and the association of a caregiver for whom the department granted a criminal history exemption.

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Child Care Audit Recommendation (August 2000)	One-Year Response (August 2001)	Bureau of State Audits' Follow-Up
To ensure that child care facilities are operating in compliance with state laws and regulations, the department should do the following:		
• Review and modify its complaints processing procedures so that all necessary complaint follow-ups occur.	The department stated that a work group was drafting changes to an existing supervisory handbook expected to have been finalized by December 2001. The department also planned to provide training in early 2002 that focused on effectively managing and monitoring field staff activities.	Although it has formal procedures for addressing complaints, the department did not consistently follow them. For example, it did not always ensure full correction of deficiencies noted and did not follow all the required procedures for complaints involving serious allegations, such as sexual and physical abuse.
• Revise its policies and procedures to require the licensing office to cite licensees within 10 days following a Regional Investigative Services investigation.	In February 2001, the department revised its evaluator manual, requiring licensing offices to cite the licensee within 10 days of receiving an investigation report.	Similar to what we had previously reported, the department did not always cite licensees within 10 days of receiving findings from its investigations unit.
• Conduct facility evaluations as required within the timelines established for child care centers and child care homes. • Track and monitor evaluations that are not performed on time until the evaluations are conducted. • Establish policies and procedures to ensure that only facility evaluations that are conducted are counted as such.	The department reported it had modified its tracking system to display facility visit histories to more accurately track due and overdue visits, but believed staff vacancies and workload increases affected its ability to complete prompt evaluations. Additionally, it modified its Licensing Information System to show facility visits attempted but not completed.	The department still did not conduct facility evaluations as required by law. Moreover, in October 2002, the Community Care Licensing Division deputy director began allowing staff to defer evaluations for those facilities meeting certain criteria. In our review of 55 facilities, we found that for six facilities the department failed to properly assess and document its reasons for deferring visits and had not evaluated 19 facilities in more than a year, including two facilities the department had not evaluated since at least 1999.
• Identify and track the evaluations of child care homes needed to meet the 20 percent requirement set by law.	The department indicated that during 2000, it met the 20 percent requirement; however, effective July 2001, it would no longer have the staff to conduct these additional visits. It expected to meet the 10 percent requirement as mandated by the Health and Safety Code. Lastly, it planned to continue tracking the number of additional visits made to meet the visit requirement.	We found that for fiscal years 2001–02 and 2002–03, the department did not meet the 10 percent requirement. In addition, although it is capable of tracking the information, it had not developed a specific system to determine its compliance in this area.

Child Care Audit Recommendation (August 2000)	One-Year Response (August 2001)	Bureau of State Audits' Follow-Up
To determine that licensing offices are properly supervising analysts' work, the department should do the following:		
• Establish standards requiring licensing offices to periodically review evaluation reports that analysts prepare. • Make certain that each licensing office is scheduling and performing its quality enhancement process evaluations as required.	The department reported that it is requiring the licensing offices to submit an annual report of all completed quality enhancement process evaluations. The licensing offices are to justify if evaluations are not completed or are delayed. The department believed this would serve to address or eliminate findings regarding insufficient staff oversight.	Despite the importance of the quality enhancement process reviews and the changes the department made to its policies, only the supervisors for the foster care program were completing the reviews as required; the supervisors of the adult and senior care program at the sites we visited generally did not.
The department should establish policies and procedures to ensure that it periodically and consistently assesses all licensing offices' operations.	The department was awaiting approval for a division-wide reorganization and hoped to create a quality control unit to periodically and consistently assess licensing offices' operations. In December 2001, the department expected to begin piloting a systems review program designed to evaluate licensing office operations.	In 2001, the division reorganized to a program-based structure focusing on the four main program areas that are responsible for conducting system reviews of their respective licensing office operations. As of July 2003, the foster care office has reviewed all of its licensing offices. However, according to the Community Care Licensing Division Operations Branch chief, the senior and adult care offices have not completed their reviews.
The department should develop and maintain a schedule to periodically review each county's child care facility licensing operations.	According to the department, it had developed a schedule to review each of the counties authorized to perform child care licensing functions and has visited those scheduled.	Thus far, for the seven counties we selected for review, the department has assessed each county's operations at least two times.
The department should reassess its goal of filing a case pleading within six months of receiving a request for legal action and strive to shorten it. Also, once it sets a more appropriate time goal, it should ensure that its processing goals for legal cases are met.	The department stated that the most serious cases are filed first and that procedures exist for expedited pleadings when requested by licensing office staff. It also believed that its ability to meet a shorter turnaround period for filing case pleadings is constrained by the increased numbers of administrative actions requested. The department reported that it hired 10 additional legal staff and reorganized its enforcement unit, which will ensure legal case processing goals are met.	The department appropriately prioritized and quickly processed cases involving legal actions against individuals who failed to comply with licensing laws and regulations.

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Child Care Audit Recommendation (August 2000)	One-Year Response (August 2001)	Bureau of State Audits' Follow-Up
The department should establish policies to guide licensing offices on the following:		
• Enforcing all license revocations and facility exclusion decisions promptly, effectively, and consistently. • Creating formal plans to monitor licensees placed on probation as a result of legal actions.	In February 2001, the department distributed to staff revised procedures for facility closures and following up to verify that an individual excluded from a facility is not present. It also provided staff with policies and procedures to use in monitoring probationary facilities.	We found that despite the revised procedures, licensing offices were not always visiting facilities on probation within 90 days of the legal decision, and, in some cases, the delays were extensive. Additionally, licensing offices could not demonstrate their follow-up activities in three revocation cases and one exclusion case because they did not document their actions.
Department of Justice		
Justice should establish a system to track notices sent to the department about individuals previously granted access to child care facilities who commit additional crimes.	Justice reported that it was redesigning its Automated Criminal History System so it can process subsequent rap sheets (subraps) electronically, and it indicated the target date is July 2003. It stated that by December 2001, it will modify the work area to enable staff to work and track individuals who were previously granted access to facilities and subsequently commit additional crimes.	Justice has streamlined its subrap processing and now forwards most to the department within a few days.
To provide the department with the most complete information, Justice should continue working to help ensure that all criminal history information is forwarded from municipal agencies to Justice in a timely manner.	Justice indicated that its Automated Tape Disposition Reporting system and the greater number of electronic fingerprint transmission devices have assisted local agencies in achieving a higher level of reporting. It also continues to work with counties initiating a system to electronically submit court dispositions, which help improve the speed and accuracy of the information they submit to Justice.	Electronic fingerprint transmission technology now allows Justice to forward the arrest information to the department more quickly because it does not have to contact the arresting authority to verify that adjudication is still pending. Further, Justice has enhanced its computer system to eliminate many of its manual processes, saving it time and reducing potential errors.

APPENDIX B

Statistics Related to the Department of Social Services' Licensing and Administrative Actions Processes

The Joint Legislative Audit Committee (audit committee) asked the Bureau of State Audits to provide, as part of this audit, various statistical data related to the processes used by the Department of Social Services (department) in licensing community care facilities. To address this request, we present information on the number of applications for licensure the department received, as well as the number of licenses that it approved, denied, had pending, or that the applicant withdrew during 2001 and 2002. Because the department contracts with 42 counties statewide to approve foster family home licenses, we have included county licensing information as well. Additionally, we present figures reflecting the department's criminal history exemptions. State law prohibits individuals with criminal histories from owning, operating, working in, or residing in community care facilities. However, state law also allows the department to grant exemptions from this requirement except to individuals convicted of certain crimes such as rape and kidnapping. Therefore, we present exemption information including the number of exemptions the department granted and denied. These data also reflect the number of people deemed ineligible for exemptions under state law.

Finally, we present the number of administrative actions the department took to revoke licenses, place licensees on probation, or issue temporary suspension orders (TSOs), which the department uses to immediately cease a facility license holder's (licensee) operation to protect clients from substantial threats to their health and safety. Because the department processes administrative actions on behalf of the counties it contracts with, the figures we present for administrative actions also include county-licensed foster family homes. The figures presented in the tables were generally provided by the department, and we did not validate the figures; thus, we cannot attest to their accuracy.

APPLICANTS FOR FOSTER CARE, ADULT CARE, SENIOR CARE, AND CHILD CARE LICENSES

As Table B.1 shows, child care facility applications represent the majority of applications the department receives. The number of applications received for foster care, adult care, and child care facilities remained relatively stable during 2001 and 2002, but the data suggest that applications for senior care facilities increased dramatically during that period. However, according to the manager of the Program Automation Support Bureau, the data may reflect a change in how the department accumulated the data. Beginning in 2002, fees collected at orientations were counted as applications received, although the potential applicants who attended the orientations might not have followed through with the application process. For the child care program, applications pending in 2002 and part of 2003 reflect the governor's moratorium. Because the department was prohibited from granting exemptions, it could not approve an application if the applicant had a criminal history. Table B.1 also shows the number of foster family home applications processed by the 42 counties with which the State contracts. The data we present reflect the department's disposition of the applications received only within the time periods specified.[1] However, the county data were not compiled in the same manner and may reflect time differences—the counties could receive an application in one year and approve it in a subsequent year. Therefore, the number of applications the counties approved, denied, had pending, or that the applicant withdrew do not add up to the number of applications the counties received.

[1] An application received in 2002, but not approved until 2003, is not included in the 2003 figures.

TABLE B.1

Applications for Foster Care, Adult Care, Senior Care, and Child Care Licenses

	Foster Care	Adult Care	Senior Care	Child Care	Department Totals	Foster Family Homes (Processed by the Counties)*
2001						
Received	1,536	653	895	13,110	16,194	4,129
Approved	1,038	535	742	10,217	12,532	2,364
Denied	33	12	12	242	299	215
Withdrawn	390	79	110	1,965	2,544	1,415
Pending	45	4	2	551	602	2,654
Other†	30	23	29	135	217	—
2002						
Received	1,400	706	2,812	13,269	18,187	3,541
Approved	823	442	658	8,595	10,518	2,158
Denied	10	3	8	100	121	192
Withdrawn	188	87	180	1,410	1,865	1,600
Pending	334	128	206	2,858	3,526	1,618
Other†	45	46	1,760	306	2,157	—
1/1/03 to 4/30/03						
Received	428	264	1,452	4,283	6,427	553
Approved	95	52	65	1,327	1,539	291
Denied	1	2	1	5	9	14
Withdrawn	18	9	17	116	160	248
Pending	278	132	248	2,485	3,143	1,636
Other†	36	69	1,121	350	1,576	—

Source: Department of Social Services.

* The county welfare departments provided the applications data for the county-processed foster family homes. The data provided for 2003 are for the period 1/1/03 to 2/28/03.

† *Other* may consist of the following:

- Application transfers between offices.
- Multiple applications for the same facility.
- Incomplete applications.

REQUESTS FOR CRIMINAL HISTORY EXEMPTIONS AND THEIR DISPOSITIONS

By law, the department must review the criminal histories of all facility owners, operators, employees, and nonclient adult residents. Table B.2 on page 92 represents the number of criminal history exemption requests the department received and granted or denied, those withdrawn, and those still in process as of April 30, 2003. However, the data are linked to

the applications presented in Table B.1. For example, for the foster care applications the department received in 2002, the department granted 454 requests for exemptions associated with these applications from the date the application was submitted through April 30, 2003. Thus, as presented, the data do not reflect the department's total exemption request workload because the department may be working exemption requests for applications it received and approved before and after 2002. On March 21, 2002, the governor issued a moratorium on child care exemptions. Until July 11, 2003, when the department reported the moratorium had been lifted, it could not notify the requestor that it had granted an exemption; however, the department continued to deny exemption requests as necessary. Therefore, the child care data are not fully representative of the exemptions the department reviewed for applications received during 2002.

TABLE B.2

Criminal History Exemptions Needed, Granted, Denied, Not Complete, and Exemptions Needed, but Not Requested as of April 30, 2003, for Applications Received During 2002

	Foster Care	Adult Care	Senior Care	Child Care	Totals
Exemptions needed	861	191	284	578	1,914
Granted	454	93	81	290	918
Denied	55	13	17	24	109
Not complete	127	41	61	143	372
Exemptions needed, but not requested	225	44	125	121	515

Source: Department of Social Services.

DENIED EXEMPTIONS

State law prohibits the department from granting criminal history exemptions to individuals who commit certain crimes, such as rape and kidnapping. Table B.3 details the number of individuals who were ineligible to receive exemptions in relation to the total number of denials as presented in Table B.2. For example, of the 55 denials for foster care facilities disclosed in Table B.2, Table B.3 indicates that 11 were for nonexemptible crimes.

TABLE B.3

Total Number of Denials for Applications Received During 2002 and Individuals Denied an Exemption for Nonexemptible Crimes

	Total Denials	Denied for Nonexemptible Crimes	Percent of Totals
Foster care	55	11	20%
Adult care	13	0	0
Senior care	17	3	18
Child care	24	2	8
Totals	**109**	**16**	**15%**

Source: Department of Social Services.

LICENSES INVOLVED IN ADMINISTRATIVE ACTIONS: REVOCATIONS, PROBATIONS, AND TEMPORARY SUSPENSION ORDERS

There are several types of possible administrative actions, including revocations, probations, and TSOs. The department's policy is to revoke a license when a licensee chronically violates licensing laws or regulations. As Table B.4 on the following page shows, the number of facilities involved in revocations remained relatively constant over 2001 and 2002. Conversely, the number of TSOs the department sought increased between 2001 and 2002. The department derived the data presented in this table from its Legal Case Tracking System, and the data reflect the total number of actions the department took in each category during the periods indicated, notwithstanding the license date or when the case was initiated. Another administrative action the department can take is an exclusion—banning an individual from community care facilities. But the audit committee did not request these figures and we have not included them here.

TABLE B.4

Licenses Involved in Administrative Actions

	Foster Care	Adult Care	Senior Care	Child Care	Totals
2001					
Revoked	243	57	83	271	654
Probation	71	50	48	130	299
Temporary suspension orders referred	5	1	3	54	63
2002					
Revoked	264	32	98	252	646
Probation	59	28	51	86	224
Temporary suspension orders referred	16	4	5	116	141
1/1/03 to 4/30/03					
Revoked	59	8	16	79	162
Probation	31	15	25	36	107
Temporary suspension orders referred	8	2	1	40	51

Source: Department of Social Services.

Note:
- Not all temporary suspension orders referred by the department are eventually served.
- *Probation* could mean one of the following:
  - The department is allowing the facility to operate under a settlement agreement.
  - The department already revoked the facility license, but gave the licensees time to relocate the residents.

Agency's comments provided as text only.

Health and Human Services Agency
Grantland Johnson, Secretary
1600 Ninth Street, Room 460
Sacramento, CA 95814

August 12, 2003

Elaine M. Howle, State Auditor*
555 Capitol Mall
Suite 300
Sacramento, CA 95814

Dear Ms. Howle:

We have reviewed your draft report entitled "Department of Social Services: Continuing Weaknesses in the Department's Community Care Licensing Programs May Put the Health and Safety of Vulnerable Clients at Risk."

I am transmitting the enclosed cover letter and comments generated by the California Department of Social Services (CDSS).

If you have any questions, please contact CDSS Director Rita Saenz at (916) 654-2598.

Sincerely,

(Signed by: Grantland Johnson)

GRANTLAND JOHNSON

* California State Auditor's comments begin on page 139.

Department of Social Services
744 P Street
Sacramento, California 95814

August 12, 2003

Ms. Elaine M. Howle, State Auditor
Bureau of State Audits
555 Capitol Mall, Suite 300
Sacramento, California 95814

Dear Ms. Howle:

This memo is in response to audit report # 2002-114 dated August 6, 2003, entitled "Department of Social Services: Continuing Weakness in the Department's Community Care Licensing Programs May Put the Health and Safety of Vulnerable Clients at Risk."

The Community Care Licensing Division of the Department of Social Services is pleased to respond to the findings and recommendations of the audit of the licensing program. The highest priority of the Community Care Licensing Division is to ensure adequate protections for the health and safety of facility clients. In keeping with this priority the Department in committed to continuous improvements in carrying out this important public trust. A brief program background and our audit report responses are enclosed.

If you have any questions regarding the information provided, please contact me at (916) 657-2598 or Dave Dodds, Deputy Director, Community Care Licensing Division.

Sincerely,

(Signed by: Rita Saenz)

RITA SAENZ
Director

Enclosure

California Department of Social Services
Response to Bureau of State Audits Findings and Recommendations
August 12, 2003

The California Department of Social Services (Department) would like to thank the Bureau of State Audits for the opportunity to respond to the various findings and recommendations of their audit of the activities of the Community Care Licensing program. In particular, we are appreciative of the auditor's recognition of the importance of the licensing program in ensuring health and safety protections to vulnerable clients in over 85,000 care arrangements, and their comments on the need to continue with our efforts to further strengthen many of the critical program components.

A large portion of the audit review and findings address the Department's criminal record clearance process. We appreciate the acknowledgement that progress has been made since the August 2000 report. Much effort has gone into strengthening this process. Rigorous standards put in place in May 2000 resulted in a dramatic reduction in the percentage of exemptions granted—from 62 percent in 1998, to 54 percent in 1999, to 32 percent in 2001. Of the nearly 275,000 persons who work or live in child care homes or centers, fewer than 2 percent currently have exemptions.

In March 2002, Governor Davis directed the Department to conduct a thorough review of the background check process. This review has been completed and, while the current system was found to be one of the most rigorous in the nation, changes were identified to make it even stronger. Regulatory changes and proposed law changes are underway that include:

- Requiring all individuals pass a criminal background check before they are allowed to be present in a licensed facility.
- Tightening criteria for exemptions by requiring longer waiting periods after a conviction before allowing an individual to be present in a facility.
- Increasing monetary penalties for licensees who allow someone to be present in a facility prior to being fingerprint cleared, or who do not comply with a Department directive to remove an individual from the facility.
- Taking rapid action to ensure that persons arrested for non-exemptible crimes are quickly removed from child care facilities.
- Proposing law change to add eleven additional violent offenses to the list of 51 crimes already in statute that permanently bar an individual from ever working or living in a licensed facility.
- Increasing Department management oversight of exemption decisions to ensure that the criteria are followed.
- Automatically denying the exemption request if the individual misrepresents their criminal background information.
- Requiring that individuals requesting an exemption submit character references using a standard form which ensures that the person making the recommendation knows that the individual they are recommending is seeking to work in child care.
- Improving county oversight by reviewing a sample of individual exemption decisions made by counties, and increasing the level of detail in the Department review processes to ensure that counties adhere to the Department exemption standards.
- Modifying data systems to improve management information and provide field staff with access to information to facilitate enforcement actions such as license revocation or removing persons who pose a risk to children in care.

As the audit recognizes in the descriptive area entitled “working environment in the Department,” the Community Care Licensing and Legal Divisions of the Department are comprised of staff involved in managing a highly complex regulatory program and who “must exercise careful judgment to strike a fine balance between the needs of the vulnerable clients the programs serve and the needs of the licensees who provide services.” The laws are complex and daily decision-making of staff impacts safety as well as the living options of over one million persons in care. We would add as well that the numbers of care arrangements, the numbers of reported incidents which must be assessed (over 400,000 per year), the numbers of complaints which must be investigated (over 15,000 per year) the numbers of applications processed (over 20,000 per year) and numbers of criminal record clearances which must be processed (over 200,000 per year) make the Community Care Licensing Program by far the largest and most protective non-medical, out of home care regulatory program in the nation.

The Department’s priority is focused on activities to protect the health and safety of facility clients. However, the State’s budget difficulties have required the Department to even more sharply concentrate staff resources in this area. In light of the reductions in available resources, the Department has established priorities for the licensing program as follows:

- Criminal Record Clearance Processing
- Complaint Investigations
- Assessment and Response to Incident Reports
- Legal Actions when Necessary to Close Facilities or Exclude Individuals from Facilities
- Verification of Corrective Actions
- Application Processing

We understand that the auditors did take into consideration the significant changes that the licensing program was going through by pulling some of their samples from the period after early October of 2002 when new priorities were established for the program by the Deputy Director. However, we do not believe that these samples necessarily represent the true uniform implementation of these changes as they exist today, since any fundamental change in a large organization cannot happen in a matter of days or weeks.

During the course of the audit, the Department continued to make organizational changes to support these new enhancements to the criminal record exemption decision process and to make the system generally work more efficiently. Many of these changes are referenced in the audit report. One of particular importance involved the centralization and consolidation of the Community Care Licensing Division’s investigators with the portion of the Caregiver Background Check Bureau dedicated to investigating arrests identified through the Department of Justice and FBI finger imaging systems. This was accomplished by reducing the numbers of staff in other areas of the licensing organization. Additional managers have also been transferred to the organization from other parts of the Community Care Licensing Division to ensure more quality control review of exemption decisions.

Shortly before the audit began, the Department had identified the dramatic increase in subsequent arrest information coming from the Department of Justice which has been referenced by the auditors. This situation presented an immediate need to add additional staff resources to the Caregiver Background Check Bureau. Staff were temporarily rotated from licensing offices in the Sacramento area. This had originally been thought to be a short-term necessity, but it was soon determined that longer term assignments would be necessary. The numbers of arrest notifications has tripled from 2,000 to 6,000 per month. In response, the Department requested 52 additional positions in the fiscal year 03-04 budget to review, investigate and file necessary legal actions related to the most serious arrests included in this three-fold growth in notifications. The 52 positions were not included in the budget for the current fiscal year. However, the Administration strongly supports establishing these essential positions in the near future.

The Department has responded to each of the recommendations provided by the California State Auditor. Despite difficulties presented by the current budget crisis, we are dedicated to continual improvement in operating this extremely important health and safety program. Realistically, we must acknowledge that some of the changes cannot be made immediately. However, we look forward to providing the required updates on progress as many of our improvement efforts that can be accomplished within existing resources are already underway.

Chapter 1

To Ensure the Protection of Vulnerable Clients in Community Care Facilities, the Department of Social Services Should Further Improve Its Process of Reviewing Criminal Histories

Over the past 18 months, the Department conducted a thorough review of its background check process and found that the current system is one of the most rigorous in the nation. Nevertheless, specific improvements were identified that would make the process even stronger. These improvements are being adopted through regulations and proposed statutory changes as the State Auditor has identified. The Department is also implementing efficiencies to streamline the work and the organization to leverage its resources. However, as a result of the severe budgetary constraints the State has experienced over the last two years, and the continued growth in workload, the Department's resources to perform all of the background check functions are being stretched beyond reasonable limits.

Item 1: To ensure that criminal history exemptions are not granted to individuals who may pose a threat to the health and safety of the clients in community care facilities:

Recommendation A:

The Department should make certain it has clear policies and procedures for granting criminal history exemptions.

Response:

The Department concurs with this recommendation. The internal review conducted over the last 18 months resulted in many process and organizational changes, both to the criminal record exemption process and the investigative process involved in follow-up on arrest information. The Caregiver Background Check Bureau has been reorganized to allow for more focus on and review of the criminal record exemption decision. To avoid delays in processing arrest and conviction notifications from the Department of Justice, a new unit structure was established preventing the need for any documents to change hands more than once. To ensure the focus on the criminal record exemption decision, the arrest-only investigation workload has been transferred to the newly developed Investigations Bureau, which represents a centralization of the Community Care Licenisng Division's Senior and Special Investigators.

Staff are finalizing new and specific desk procedures for all staff involved in screening rap sheets, for staff who review exemption requests, and for staff who process and investigate arrest information. These procedures detail the elements to consider in making the case decisions and the supervisory review criteria.

Chapter 1

To Ensure the Protection of Vulnerable Clients in Community Care Facilities, the Department of Social Services Should Further Improve Its Process of Reviewing Criminal Histories

Item 1: To ensure that criminal history exemptions are not granted to individuals who may pose a threat to the health and safety of the clients in community care facilities:

Recommendation B:

The Department should ensure staff are trained on the types of information they should obtain and review when considering a criminal history exemption such as clarifying self-disclosed crimes and vague character references.

Response:

The Department concurs with this recommendation. With the improvements recently made to strengthen the background check process, it was necessary to provide more intensive training to staff on the entire process and this training is now being developed. Staff have already received extensive training on the changes to the exemption decision-making process that resulted from the process review required by the Governor. As the new requirements will fundamentally change the exemption process, training modules are also being prepared that will address the entire system for reviewing and making decisions on exemptions. This training approach is also being utilized because of the large number of new staff who are being re-directed to assist in the processing of criminal history information. As noted, training will be re-enforced with written desk procedures and ongoing training as further changes are made.

Chapter 1

To Ensure the Protection of Vulnerable Clients in Community Care Facilities, the Department of Social Services Should Further Improve Its Process of Reviewing Criminal Histories

Item 1: To ensure that criminal history exemptions are not granted to individuals who may pose a threat to the health and safety of the clients in community care facilities:

Recommendation C:

The Department should review its character reference form to be certain the form's instructions are fully consistent with criminal history exemption guidelines.

Response:

The Department concurs with this recommendation, but notes that these changes were accomplished during the review of the entire criminal record clearance process that was directed by the Governor on March 21, 2002. The Department has designed and implemented a new character reference form to strengthen the background check process. The form requires specific responses to standardized questions about the individual requesting an exemption. The form ensures that the individual providing a character reference understands that the individual is applying to work in a care facility. However, since the Department cannot disclose the nature of the crimes, no mention of a criminal history is made on this form. The Department has ensured that the form's instructions are fully consistent with the criminal history exemption guidelines.

Chapter 1

To Ensure the Protection of Vulnerable Clients in Community Care Facilities, the Department of Social Services Should Further Improve Its Process of Reviewing Criminal Histories

Item 2: To process criminal history reviews as quickly as possible so that delays do not impede individuals' right to work or its licensed facilities' ability to operate efficiently:

Recommendation A:

The Department should work to make certain that staff meet established time frames for notifying individuals that they must request a criminal history exemption and for making exemption decisions as requested.

Response:

The Department concurs with this recommendation in principle. However, the current time frames, which are internal guidelines only, are dependent upon staff resources and may require lengthening given the current budget situation. It is also noted that the Department has recently adopted regulations that will require completion of a criminal background check prior to an employee beginning work in a facility. With the implementation of the clearance before work component, individuals can no longer start work or be present in the facility prior to being cleared. Previously, it was most important to ensure individuals with serious crimes (i.e. non-exemptible, felonies, and violent misdemeanors) be removed immediately from a facility pending an exemption decision (Note: this will not change for individuals subsequently arrested or convicted for serious crimes after they have initially received a clearance). Clearance before work allows the Department to reassess its work priorities. Since individuals are not in the facility until they are cleared or given an exemption, the priority will be shifted to clear or exempt individuals as quickly as possible to allow them to work.

For those individuals with criminal histories, the clearance before work requirement ensures that they are not present in facilities until they have received an exemption. As the State Auditor has pointed out, we do not want to "impede an individuals' right to work." The Department agrees that realistic time frames should be established and met whenever possible. Given the limitations on staffing, the Department will re-prioritize the work associated with individuals with lesser crimes or infractions, who represent the largest majority of workload, and now give this work higher priority. This will give priority to those individuals who can be in a facility as quickly as possible. Those individuals requiring a standard exemption, including individuals with more serious criminal histories, will take longer to process.

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Chapter 1

To Ensure the Protection of Vulnerable Clients in Community Care Facilities, the Department of Social Services Should Further Improve Its Process of Reviewing Criminal Histories

Item 2: To process criminal history reviews as quickly as possible so that delays do not impede individuals' right to work or its licensed facilities' ability to operate efficiently:

Recommendation B:

The Department should assess its quality control review process and ensure that these policies and procedures encompass a review of the key elements of the exemption decision process and staffs' completing appropriate and necessary correspondence.

Response:

The Department concurs with this recommendation. As was mentioned in the State Auditor's report, the Department is continuing to change its quality control process to improve its effectiveness. Improved procedures are being developed and additional management staff are being redirected to complete quality control reviews. The criminal record clearance process and management oversight of decision-making will remain priority activities.

Chapter 1

To Ensure the Protection of Vulnerable Clients in Community Care Facilities, the Department of Social Services Should Further Improve Its Process of Reviewing Criminal Histories

Item 3: So that investigations of arrest-only information are properly tracked:

Recommendation A:

The Department should develop a process for the Background Information Review Section (BIRS) to record when it refers a case for investigation.

Response:

The Department concurs with this recommendation. Along with our recent reorganization of the Caregiver Background Check Bureau, we have implemented a process to identify cases that are referred to the field for investigation. On September 1, 2003, the Department will be implementing a system that will track an arrest referral through the investigative process. The system will generate a listing of cases that have been referred to the field and will prompt the BIRS analysts to inquire as to the status of the investigation.

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Chapter 1

To Ensure the Protection of Vulnerable Clients in Community Care Facilities, the Department of Social Services Should Further Improve Its Process of Reviewing Criminal Histories

Item 3: So that investigations of arrest-only information are properly tracked:

Recommendation B: The Department should track a case to make certain that an investigation takes place.

Response

The Department concurs with this recommendation. As mentioned in our previous response, on September 1, 2003, we will be implementing a system that will track an arrest referral through the investigative process. The system will generate a listing of cases that have been referred to the field and prompt the BIRS analyst to inquire as to the status of the investigation.

In addition, in March of 2003 the Background Information Review Section and the Community Care Licensing Division investigators were reorganized into one Bureau. The realignment has resulted in improved controls for arrest investigations referred to the field.

Chapter 1

To Ensure the Protection of Vulnerable Clients in Community Care Facilities, the Department of Social Services Should Further Improve Its Process of Reviewing Criminal Histories

Item 3: So that investigations of arrest-only information are properly tracked:

Recommendation C:

The Department should ensure that policies and procedures are consistent and clear on where the responsibility lies for ensuring that the necessary action occurs upon an investigation's completion.

Response:

The Department concurs with this recommendation. We have developed a procedure that clearly gives the investigators instruction on the procedures to be used when closing an investigation and reporting the findings to the Regional Office and to BIRS. In addition, the tracking system to be implemented September 1, 2003, will generate a listing of arrest only cases that have been referred to field staff for completion of the investigation. The procedures have clarified the responsibility for ensuring that these investigations are completed. The listing will be used by the Regional Office as a tool to track investigations that are being conducted.

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Chapter 1

To Ensure the Protection of Vulnerable Clients in Community Care Facilities, the Department of Social Services Should Further Improve Its Process of Reviewing Criminal Histories

Item 3: So that investigations of arrest-only information are properly tracked:

Recommendation D:

The Department should review and enforce its arrest-only policies and procedures to ensure that it is issuing criminal history clearances only when appropriate to do so.

Response:

The Department concurs with this recommendation. The Department has reviewed the arrest only procedures and policies used when making a criminal record history clearance determination. Procedures were developed in July, 2003 that address the clearance criteria for arrests. The procedure for investigating arrest cases with a court diversion status has also been developed and implemented. The procedure calls for the investigation of all arrests that are on court diversion status and is not dependent upon court disposition.

A BIRS procedural manual is being developed and staff will be trained on the procedures.

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Chapter 1

To Ensure the Protection of Vulnerable Clients in Community Care Facilities, the Department of Social Services Should Further Improve Its Process of Reviewing Criminal Histories

Item 3: So that investigations of arrest-only information are properly tracked:

Recommendation E:

The Department should properly train staff on these policies and procedures.

Response:

The Department concurs with this recommendation. Training and written procedures are an integral part of our implementation strategies. At the time that the investigators were centralized into the new Bureau, a new Investigator's Procedure Manual was developed. Training is accomplished through weekly staff meetings and through updates to the Investigator manual. As was mentioned previously, procedures continue to be developed and ongoing training will be provided as procedures are adopted.

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Chapter 1

To Ensure the Protection of Vulnerable Clients in Community Care Facilities, the Department of Social Services Should Further Improve Its Process of Reviewing Criminal Histories

Item 3: So that investigations of arrest-only information are properly tracked:

Recommendation F:

The Department and the Department of Justice (DOJ) should work together to identify what, if any, additional information, such as convictions or diversions, the Department may need to make reasonable and appropriate criminal history decisions after receiving arrest-only information. They should then arrange for DOJ to provide the needed information.

Response:

The Department concurs in principle. However, the DOJ currently does not provide subsequent conviction information to Department. We have identified this information as necessary to make appropriate decisions regarding an individual's criminal record history. We have requested access to the information and will continue to work with DOJ to obtain it. The DOJ has provided an estimate of $506,000 in one time costs and $155,000 per year ongoing costs for this purpose. The Department will explore obtaining the additional resources needed to obtain and follow-up on subsequent convictions.

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Chapter 1

To Ensure the Protection of Vulnerable Clients in Community Care Facilities, the Department of Social Services Should Further Improve Its Process of Reviewing Criminal Histories

Item 4: To ensure that the Department can account for all subraps it receives and that it processes this information promptly:

Recommendation A:

The Department should develop and implement a policy for recording a subrap's receipt and train staff on this policy.

Response:

The Department concurs with the recommendation and has implemented an enhancement to its current system which allows for better tracking when the Department receives subraps. The corresponding policies, procedures, and training plans are being developed. The enhancement will increase the Department's ability to track all subraps it receives. Information will be processed as promptly as resources allow.

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Chapter 1

To Ensure the Protection of Vulnerable Clients in Community Care Facilities, the Department of Social Services Should Further Improve Its Process of Reviewing Criminal Histories

Item 4: To ensure that the Department can account for all subraps it receives and that it processes this information promptly:

Recommendation B:

The Department should ensure that, upon receiving a subrap with conviction, staff meet established time frames for notifying individuals that they need an exemption.

Response:

The Department does not routinely receive this information as we indicated earlier. However, we do concur that were we to receive subsequent conviction information, timely notification is important.

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Chapter 1

To Ensure the Protection of Vulnerable Clients in Community Care Facilities, the Department of Social Services Should Further Improve Its Process of Reviewing Criminal Histories

Item 5: So that the Department's licensing staff have accurate information about who should or should not be in a facility, thereby helping to protect clients:

Recommendation A:

The Department should meet its established time frame for notifying licensing staff and facility owners/operators that an individual has not submitted a criminal history exemption request as necessary and may no longer be present in a facility.

Response:

Following the Department's implementation of new regulations requiring criminal record clearances before work, the speed of the notification no longer impacts the safety of clients in care. We realize that we still have an obligation to notify individuals and licensees when an exemption request is necessary, but the notification time frames will need to realistically reflect available staff resources.

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Chapter 1

To Ensure the Protection of Vulnerable Clients in Community Care Facilities, the Department of Social Services Should Further Improve Its Process of Reviewing Criminal Histories

Item 5: So that the Department's licensing staff have accurate information about who should or should not be in a facility, thereby helping to protect clients:

Recommendation B:

The Department should assess its FBI background check practices to ensure that it is fully aware of an individual's criminal record should that individual have a two-year or less gap in employment in community care.

Response:

The Department agrees that it should be fully aware of an individual's criminal record that is available to the Department. The FBI does not offer subrap services and thus this information is not available.

Presently, the only way to obtain this information would be to change statute and require an individual to reprint for an FBI check every time an individual disassociates from (i.e., leaves) a community care facility and returns to work within the two years. This will result in an added cost to process the additional workload, and a significant additional burden for licensees. Even if the individual has no criminal activity, the screening, input and processing of the rap sheet must be completed. Given the current resource constraints, the Department will need to further assess this issue and its ability to take on additional workload.

Chapter 2

Shortcomings in Its Procedures Prevent the Department of Social Services From Effectively Protecting all Clients Against Unsafe and Unhealthy Environments in Community Care Facilities

Over the past two years, the Department has taken many steps to ensure the highest priority work is completed while staffing levels to carry out these duties continued to decrease. In late 2001, the annual visit process was streamlined to focus our limited staff resources on non-compliant facilities. In October 2002, the Department implemented a workload plan which identified seven priority activities. In 2003, the Department developed a targeted visit protocol which requires annual visits to facilities with a history of non-compliance as well as a sample of all other facilities. This new visit protocol was approved by the Legislature in the 2003-04 Budget Act. The protocol will be implemented in September 2003.

Complaint investigations continue to be the Department's top priority. This will be re-emphasized to licensing analysts in the Deputy Director's new visit protocol memo scheduled for release in September 2003.

The Department continues to focus its staff resources on facility visits that will best protect clients in community care facilities.

Item 1: To ensure that complaints are promptly and thoroughly investigated and that facilities correct deficiencies:

Recommendation A:

The Department should continue to emphasize complaint investigations over other duties.

Response:

The Department concurs with the need to continue to emphasize complaint investigations as a priority over other functions within the Department. We believe that the findings in this area were primarily the result of problems in one of our 25 licensing offices, which has now been addressed. We do not believe that these findings represent a systemic problem. Prioritizing complaint investigations commits the Department's limited resources to providing a quick response when we are made aware of potential problems that can impact the care of facility clients. We will continue to make this a priority for our staff. The Deputy Director will issue a memo to field staff in September 2003, re-emphasizing complaint investigations as the Department's highest priority.

Chapter 2

Shortcomings in Its Procedures Prevent the Department of Social Services From Effectively Protecting all Clients Against Unsafe and Unhealthy Environments in Community Care Facilities

Any deficiencies in these areas identified by the auditors will continue to receive particular attention by the Department in corrective actions. We do understand that the methodology used to sample activities reviewed did not provide statistical reliability. For example, findings regarding response to complaints were based on reviews of 75 complaints in three of our 25 licensing offices out of a total of over 15,000 complaints received annually. However, we will assume, as do the auditors, that any negative findings in these areas are indications that more effort is needed, and will continue to focus our available resources on these improvements. At the same time, the reduced resources with which the Community Care Licensing Division is working means that we must continually assess where to focus these limited resources with the primary focus being the impact on client health and safety.

Item 1: To ensure that complaints are promptly and thoroughly investigated and that facilities correct deficiencies:

Recommendation B:

The Department should require analysts to begin investigating complaints within 10 days of receiving complaints and, whenever possible, to resolve investigations within 90 days.

Response:

The Department concurs with this recommendation. The majority of complaint investigations are initiated within 10 days and completed and signed off by the supervisor within 90 days. We believe that the great majority of findings in this area resulted from problems in one of our 25 licensing offices. The issues in this office have now been addressed. The 90-day provision is a guideline used to encourage the timely resolution of complaints. There are instances where investigative circumstances require more than the prescribed 90 days to arrive at a valid conclusion. Examples of these circumstances may include delayed toxicology reports, coordinating with law enforcement and locating key witnesses who are out of the area.

Chapter 2

Shortcomings in Its Procedures Prevent the Department of Social Services From Effectively Protecting all Clients Against Unsafe and Unhealthy Environments in Community Care Facilities

Item 1: To ensure that complaints are promptly and thoroughly investigated and that facilities correct deficiencies:

Recommendation C:

The Department should ensure that analysts follow policies requiring them to refer to the investigations unit any serious allegation within eight hours of receipt and issue citations for serious allegations the investigations unit has substantiated within 10 days of receipt.

Response:

We concur that procedures should be followed for referring serious allegations within eight hours to the investigations unit. In May 2003, the Department completed statewide training for adult and senior care program staff that included complaint investigation referral protocol, policy and procedures. Within the past two years, similar training was conducted for child care and children's residential program staff. The Department has recently reorganized the investigation section with the intent to improve the coordination, referral and completion of more serious complaints filed against facilities. The audit findings demonstrate the need for the Department to reemphasize to field staff that more serious complaints must be appropriately referred to the investigations unit.

We concur that in most instances regional office citations for licensing violations should occur within ten days of receipt of substantiated findings from the bureau of investigations. More time may be necessary if the regional office disagrees with the finding, is investigating other elements of the complaint, feels that more investigation is necessary, or is requested by a law enforcement agency to delay the issuance of the citation due to a criminal investigation. We will reemphasize the policy to issue a citation within ten days of receiving a substantiated complaint from the bureau of investigation with all field staff, whenever these other conditions are not present.

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Chapter 2

Shortcomings in Its Procedures Prevent the Department of Social Services From Effectively Protecting all Clients Against Unsafe and Unhealthy Environments in Community Care Facilities

Item 1: To ensure that complaints are promptly and thoroughly investigated and that facilities correct deficiencies:

Recommendation D:

The Department should make sure that abuse allegations that are deemed inconclusive are reviewed with the legal Department.

Response:

The Department concurs in principle with the recommendation. The procedure which was reviewed by the Bureau of State Audits was put into effect by the Deputy Director at the request of the Director to ensure that an inconclusive finding was an appropriate one when the complaint allegation was serious. In December 2002, we modified the procedure and now require the Regional Manager to involve legal staff in all top priority complaint investigations, including, but not limited to those that may result in an inconclusive finding. These new procedures were disseminated in November of 2002 and incorporated into the evaluator manual.

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Chapter 2

Shortcomings in Its Procedures Prevent the Department of Social Services From Effectively Protecting all Clients Against Unsafe and Unhealthy Environments in Community Care Facilities

Item 1: To ensure that complaints are promptly and thoroughly investigated and that facilities correct deficiencies:

Recommendation E:

The Department should require supervisors to review evidence that facilities took corrective action before signing off on a complaint.

Response:

The Department concurs that supervisors should ensure that complaints are thoroughly investigated and that facilities correct deficiencies identified in the complaint process. Currently the supervisor signs off on the complaint when he/she is satisfied that the LPA has conducted a thorough investigation, has arrived at the correct finding, and has developed an appropriate plan of correction. The supervisor monitors completion of the facility's plan of correction through his/her own complaint logs, discussions with the LPA, and review of the LPAs control book. Because of the Department's increasing emphasis on complaints as the top priority and the concern that all corrections be completed, the Department will be looking at this area. The Department will increase supervisory oversight to ensure that corrections are made within required timeframes.

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Chapter 2

Shortcomings in Its Procedures Prevent the Department of Social Services From Effectively Protecting all Clients Against Unsafe and Unhealthy Environments in Community Care Facilities

Item 2: To make certain that certified foster parents correct identified inappropriate behaviors:

Recommendation A:

The Department should require foster family agencies to ask each applicant whether he or she had uncorrected substantiated complaints at any other foster family agency.

Response:

The Department concurs with this recommendation but believes it should be expanded to include a requirement that agencies always determine all previous certification history for any home under consideration that has been formerly certified by another agency. The Department will develop regulations to require foster family agencies to conduct these reviews which would include determining any uncorrected substantiated complaints from a previous foster family agency. The Children's Residential Program is currently developing a technical assistance guide for foster family agencies on steps to take when certified family home parents transfer from one foster family agency to another.

Currently if a foster family agency decertifies a certified family home for cause, this information is entered into the Licensing Information System. If these parents move to another foster family agency, it will show up on the new certified family home list submitted monthly by the new foster family agency. Licensing staff will notify the new foster family agency of any certified family home's prior decertification.

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Chapter 2

Shortcomings in Its Procedures Prevent the Department of Social Services From Effectively Protecting all Clients Against Unsafe and Unhealthy Environments in Community Care Facilities

Item 2: To make certain that certified foster parents correct identified inappropriate behaviors:

Recommendation B:

The Department should require the foster family agency to verify the accuracy of the applicant's statements with the applicant's immediate prior foster family agency.

Response:

We concur with this recommendation. The Department will develop regulations to require foster family agencies to verify the accuracy of a certified family home applicant's statements with the applicant's prior foster family agency.

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Chapter 2

Shortcomings in Its Procedures Prevent the Department of Social Services From Effectively Protecting all Clients Against Unsafe and Unhealthy Environments in Community Care Facilities

Item 3: To ensure that it issues licenses only to qualified individuals:

Recommendation A:

The Department should ensure that analysts follow the check list in collecting and considering all required information before it grants applicants' licenses including, but not limited to health screening reports, administrator's certification, and necessary background checks.

Response:

We concur with this recommendation. Analysts should collect, review and approve all required information before granting a license. This continues to be our expectation of the licensing worker. The checklist mentioned in the audit finding was developed by the Department to ensure that all information necessary to approve a license was received.

All of the deficient documents have now been obtained for the files identified by the auditors. Each of the Program Administrators have been directed to review the application process for each program and to report back to the Deputy Director on plans to better assure that all verifications are complete at the time licenses are issued. These plans may vary slightly for each program as some of the requirements are different. These plans are due to the Deputy Director by October 1, 2003.

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Chapter 2

Shortcomings in Its Procedures Prevent the Department of Social Services From Effectively Protecting all Clients Against Unsafe and Unhealthy Environments in Community Care Facilities

Item 3: To ensure that it issues licenses only to qualified individuals:

Recommendation B:

The Department should conduct the necessary post-licensing evaluations within the required time frame to make certain that newly licensed caregivers are operating in compliance with the regulations.

Response:

The Department concurs with this recommendation in principle; however, during the time period covered by the audit, limitation in staffing resources required the establishment of visit priorities. The pre-licensing visit was prioritized over the post licensing visit in an October 2002 all-staff memo issued by the Deputy Director. In addition, it is not uncommon to postpone the post licensing visit. In addition, it is not uncommon to postpone post licensing visits when the licensing analyst knows that the facility does not have any clients present. The Department is currently considering the elimination of post licensing visits as a means of dealing with anticipated additional staff shortages.

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Chapter 2

Shortcomings in Its Procedures Prevent the Department of Social Services From Effectively Protecting all Clients Against Unsafe and Unhealthy Environments in Community Care Facilities

Item 4: If the Department plans to continue to defer required facility evaluations:

Recommendation A:

The Department should seek legislative approval for its deferral plans.

Response:

The audit does identify that the Community Care Licensing Division is not making all required visits. This is an accurate finding and one that we have knowingly been tracking internally. However, we believe conscious decisions to forego some of these visits were necessary given the reduction in available staff resources.

We do, however, agree that we have a responsibility to seek legislative permission in these situations and that is exactly what we have done. In the current budget, the visit protocols have been statutorily modified in line with the priorities mentioned above. The Department sought and received legislative approval through the 2003-04 Budget Act to implement a sample visit protocol for ten percent of the licensed facilities in the state. The 10% annual visit protocol requires annual visits to all facilities with a history of noncompliance. The new targeted visit approach will bring the Department's annual visit protocols into compliance with statute. The legislatively approved targeted visits are anticipated to begin in September 2003.

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Chapter 2

Shortcomings in Its Procedures Prevent the Department of Social Services From Effectively Protecting all Clients Against Unsafe and Unhealthy Environments in Community Care Facilities

Item 4: If the Department plans to continue to defer required facility evaluations:

Recommendation B:

Ensure staff understand the guidance on visits that qualify for deferral and that staff are properly implementing the deferral policy.

Response:

In October 2002, the Department implemented the deferred visit protocols to manage severe staffing shortages that restricted our ability to meet annual visit mandates until legislative relief could be received. The Department sought and received legislative approval to implement targeted annual visits through the 2003-2004 Budget Act. The targeted visits will be implemented in September 2003. The Department is developing instructions for field staff that will provide guidance regarding the targeted visit protocols that will be incorporated into the evaluator manual. Staff training will also be an important component of the implementation of the new protocols.

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Chapter 2

Shortcomings in Its Procedures Prevent the Department of Social Services From Effectively Protecting all Clients Against Unsafe and Unhealthy Environments in Community Care Facilities

Item 4: If the Department plans to continue to defer required facility evaluations:

Recommendation C:

The Department should modify its licensing information system so that when it defers a visit to a childcare home, the visit would be deferred for one year – similar to other facility types – as compared to a full three years.

Response:

Because of the need to reduce general fund expenditures, through the budget process the Department proposed replacement of the current triennial visit requirements with a targeted visit protocol. The recently adopted budget provides for visits to all problem facilities defined by specific criteria and to a 10% random sample of all remaining facilities. Procedures and instructions for field staff are being developed for implementation in September 2003. At that time the Department will discontinue its current procedures for deferring visits and it will not be necessary to modify the Licensing Information System to track these deferred visits. The system will be modified to track the new targeted visits.

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Chapter 2

Shortcomings in Its Procedures Prevent the Department of Social Services From Effectively Protecting all Clients Against Unsafe and Unhealthy Environments in Community Care Facilities

Item 5: Because it receives supplementary assurance that childcare homes are operating in accordance with licensing requirements between triennial visits:

Recommendation A:

The Department should track its compliance with and meet the requirement that 10% of all child care homes be visited annually.

Response:

The Department no longer has a requirement to complete this 10% visit. Because of the need to reduce the Department's general fund expenditures, the new budget for fiscal year 03/04 has eliminated all mandated visits currently in statute and replaced them with a targeted visit protocol. This specific requirement for visits to ten percent of all child care homes is no longer in statute. Annual visits are now required to all targeted problem facilities and to a 10% random sample of all remaining child care facilities. The new visit protocol will be implemented in September, 2003. These visits will be tracked through an automated system which will produce lists of visits required by each Licensing Program Analyst.

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Chapter 2

Shortcomings in Its Procedures Prevent the Department of Social Services From Effectively Protecting all Clients Against Unsafe and Unhealthy Environments in Community Care Facilities

Item 5: Because it receives supplementary assurance that childcare homes are operating in accordance with licensing requirements between triennial visits:

Recommendation B:

If the Department determines it cannot meet the 10% requirement, it should work with the legislature to modify the law or develop a plan to fulfill the requirement.

Response:

Please see the response to the recommendations for item 5, recommendation A. As noted, the Department's budget for fiscal year 03/04 has eliminated all mandated visits currently in statute, including triennial visits to child care homes and this requirement for visits to 10% of all child care homes annually. Annual visits to all targeted problem facilities and to a random sample of all remaining child care facilities will be implemented effective September 2003.

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Chapter 2

Shortcomings in Its Procedures Prevent the Department of Social Services From Effectively Protecting all Clients Against Unsafe and Unhealthy Environments in Community Care Facilities

Item 6: To ensure that analysts are adequately supervised and trained:

Recommendation A:

The Department should make certain that all licensing office supervisors are conducting complete and prompt quality enhancement process reviews of their assigned analysts.

Response:

We concur in principle with the need for complete and timely Quality Enhancement Process (QEP) evaluations. Inability to fill field supervisor positions has meant that existing supervisors have had to take responsibility for far greater numbers of analysts. This has increased span of control problems for supervisors in such areas as staff evaluations and case file reviews, which are two areas of concern in the audit findings. In many cases, supervisors are now doing licensee orientations and facility visits when other staff resources are not available, so that analyst staff can focus on facility visits.

The licensing supervisor is required to complete two separate performance evaluations each year for each licensing analyst. One is the Department's Individual Development Plan (IDP), which is required annually. The IDP gives an assessment of the licensing analyst's work, indicates where improvement is needed, and establishes goals for the next year. The other evaluation is the QEP, which is not a statutory mandate of the Department. In offices with severe staffing shortages, we plan to temporarily suspend the requirement for QEPs.

The Department has developed a Supervisory Handbook that addresses the licensing supervisor's responsibility to review the licensing analyst's work on a continuous basis. Some examples of the review process are reviews of complaint investigations, applications, problem facility files and waivers and exceptions. The supervisory reviews provide the opportunity for the supervisor to identify any problem areas and work directly with the program analyst to immediately correct them.

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Chapter 2

Shortcomings in Its Procedures Prevent the Department of Social Services From Effectively Protecting all Clients Against Unsafe and Unhealthy Environments in Community Care Facilities

Item 6: To ensure that analysts are adequately supervised and trained:

Recommendation B:

The Department should make available to analysts the necessary training and develop a method to track whether analysts are meeting statutory training requirements.

Response:

We believe that training is a critical component of the Community Care Licensing Division program and our goal is to continue to provide as much training as possible to meet the statutorily mandated requirements. Budgetary constraints have significantly reduced our ability to access contract training monies that had been available. The Department is currently exploring alternative ways to meet these requirements such as developing training modules for supervisory staff to be delivered during unit meetings, on-line training and the utilization of more local training resources.

We have recently completed the development of a new more user friendly database to track staff training. It was successfully piloted for three months in the northern region of the state and distributed to Program Trainers and the Department's Central Training Section. New data base training will be conducted within the next three months for all trainers.

Travel restrictions have been necessary due to required reductions in the Community Care Licensing Division's operating expenses. The established priority use of travel money is to ensure that licensing analysts can make complaint and evaluation visits to care facilities. This has meant that we have had to dramatically reduce formal training opportunities for all licensing staff. We have also had to rely upon local managers and supervisors to provide training needed to implement program changes.

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Chapter 3

Although the Department of Social Services Should Monitor Counties' Performance More Diligently, Fresno and Kern Counties Generally Administered Their Programs Effectively Except for Complaint Processing

The Department contracts with 42 counties throughout California to operate the licensing program for Foster Family Homes. In these contracted counties, the County is responsible for all of the licensing activities necessary to license and monitor Foster Family Homes.

The Department has oversight responsibility to ensure compliance with the Memorandum of Understanding (MOU) for each of these counties.

County oversight is provided through the Department County Liaison staff. The Liaisons provide ongoing consultation regarding clarification of applicable laws, regulations and policies and provide guidance to counties regarding complaint investigations. The Liaisons regularly attend county licensing supervisory meetings to provide licensing information and to train county staff.

Item 1: To help ensure that counties contracting with the Department to license and monitor foster family homes adequately and promptly respond to complaints and enforce corrective actions:

Recommendation A:

The Department should establish a reasonable time frame for liaisons to prepare reports resulting from reviews of the counties and to notify counties of the results of those reviews.

Response:

The Department concurs with this recommendation. There is a ten (10) day turn around time required for County Liaisons to complete their written report upon completion of County Reviews. To date, the county reviews have been conducted on a timely basis for all of the 42 contracted counties. To ensure that the ten-day standard for reports will be met, a new tracking system has been developed and will be implemented by September 30, 2003. This will enable the Program Manager to track all county reviews, reports and follow up on corrective action plans.

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Chapter 3

Although the Department of Social Services Should Monitor Counties' Performance More Diligently, Fresno and Kern Counties Generally Administered Their Programs Effectively Except for Complaint Processing

Item 1: To help ensure that counties contracting with the Department to license and monitor foster family homes adequately and promptly respond to complaints and enforce corrective actions:

Recommendation B:

The Department should also establish a reasonable time frame in which all counties must submit and complete their corrective action plans.

Response:
The Department concurs with this recommendation. The county liaison program is currently developing a formal corrective action plan that will require specific time frames for each area reviewed. This procedure will be implemented by October 2003.

The county is given technical assistance and guidance throughout the entire corrective action planning process by the county liaison.

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Chapter 3

Although the Department of Social Services Should Monitor Counties' Performance More Diligently, Fresno and Kern Counties Generally Administered Their Programs Effectively Except for Complaint Processing

Item 1: To help ensure that counties contracting with the Department to license and monitor foster family homes adequately and promptly respond to complaints and enforce corrective actions:

Recommendation C:

The Department should create a reliable method for tracking county corrective actions to ensure they are not overlooked.

Response:
The Department concurs with this recommendation and places a high priority on timely response to ensure compliance and enforcement of corrective actions. The County Liaison Program is currently developing a reliable method for tracking county corrective actions which will be implemented in September 2003.

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Chapter 3

Although the Department of Social Services Should Monitor Counties' Performance More Diligently, Fresno and Kern Counties Generally Administered Their Programs Effectively Except for Complaint Processing

Item 2: To help ensure that counties contracting with the Department to license foster family homes are making reasonable decisions regarding criminal history exemptions:

Recommendation A:

The Department should develop procedures to ensure that it promptly and consistently reviews quarterly reports on exemptions granted by each contracted county.

Response:

The Quarterly County Exemption Reporting (QER) process has been in place since July 2002. All 42 counties have been trained on this process during a statewide training held July through August 2002. Follow-up teleconference training was given to the counties during the month of November 2002. The QER process has been continually reviewed with all counties individually and at the quarterly Licensing Supervisors meetings held throughout the state by the county liaisons.

All counties submit a QER directly to the county liaisons who then forward the report to the Caregiver Background Check Bureau for review, since Caregiver Background Check Bureau is the Departmental expert in this area. If during the Caregiver Background Check Bureau review of the QER more information is required to explain why an exemption was granted, requests for additional information are forwarded to the county liaison who is responsible for getting the information from the county and back to the Caregive Background Check Bureau. In those cases where exemptions may not have been appropriately granted specific directions are given to the county by the Caregiver Backgroun Check Bureau and/or legal to correct or amend their decision.

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Chapter 3

Although the Department of Social Services Should Monitor Counties' Performance More Diligently, Fresno and Kern Counties Generally Administered Their Programs Effectively Except for Complaint Processing

Item 3: To be certain they adequately investigate all complaints against foster family homes and ensure that deficiencies are corrected:

Recommendation A:

The county should follow current policy and any policy changes the Department implements as a result of the recommendations in this report.

Response:

The Department concurs with this recommendation made to Fresno and Kern Counties and will continue to provide any needed technical assistance.

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Chapter 3

Although the Department of Social Services Should Monitor Counties' Performance More Diligently, Fresno and Kern Counties Generally Administered Their Programs Effectively Except for Complaint Processing

Item 4: To ensure that a facility on probation complies with the terms of the probation:

Recommendation A:

Kern County should abide by the Department's procedure and make a compliance visit to the facility within 90 days following the legal decision.

Response:

The Department concurs with this recommendation to Kern County and will continue to provide any needed technical assistance.

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Chapter 4

The Department of Social Services Improved the Timeliness of Its Processing of Legal Actions But Could Do More to Enforce the Resulting Decisions

Item 1:

To ensure that enforcement actions against facilities are carried out:

Recommendation A:

The Department should conduct follow-up visits and document its follow-up for enforcement of revocation and exclusion cases.

Response:

The Department agrees with the need to ensure that any administrative actions taken against facilities are enforced. In the new procedures for visits to targeted facilities, visits to facilities on probation are clearly identified as a high priority. Those facilities on probation will be identified at the time the hearing decision or stipulation is signed as requiring visits. These facilities will be tagged in the automated system, and the visits due will show up in the visit list for each LPA. Supervisors receive copies of the visit due lists and will be able to monitor to insure that they are all completed and documented through the standard field visit report.

Exclusion actions have represented a very large portion of the Department's administrative actions. We believe that the new requirement for clearance before work will result in fewer exclusion actions as in most cases people excluded for criminal record clearances will not initially be allowed in the facility. When it is necessary to verify that excluded individuals have in fact been excluded, the confirmation of removal process developed by the Department will be adapted for use by the Regional offices.

For revocation cases, the Department will reinforce current procedures which require the licensing program analyst to verify that the facility has ceased operation. The visit will be documented on a standard field visit report and placed in the closed facility file.

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COMMENTS

California State Auditor's Comments on the Response From the Department of Social Services

To provide clarity and perspective, we are commenting on the Department of Social Services' (department) response to our audit report. The numbers correspond with the numbers we have placed in the department's response.

- We are not suggesting that the department should disclose the applicants' criminal history; however, we would expect the applicant to be instructed to ensure that the references have knowledge of the applicant's criminal past and consider that information when completing the character reference form. Despite the revisions the department made to the form in July 2003, the department has not yet addressed the reference's knowledge of the applicant's criminal past.

- Although we acknowledge on page 45 that the Sacramento licensing office accounted for a majority of the late initial visits, we noted this problem at all three licensing offices we visited. The department should consider the possibility that the problem may exist at the other 22 licensing offices that we did not visit. Without an audit of the other 22 licensing offices, the department lacks sufficient evidence to know whether or not these findings represent a systemic problem.

- As we stated on page 45, the Sacramento licensing office largely accounted for the late initial visits that we found; however, this was not the case for investigations that exceeded 90 days. We had concerns with the ability of each of the three licensing offices we reviewed to complete investigations within 90 days. Additionally, although we acknowledge on page 46 that certain circumstances may delay an investigation, we also point out that these circumstances did not exist for the complaints we reviewed. Rather, we were told other work and priorities had delayed the investigations.

- As we state on page 58 of our report, in response to our child care report the department re-emphasized the importance of quality enhancement processes (QEPs). Moreover, we believe the

QEP has value because its design is specific to the work that the department's analysts do. However, to the extent the supervisors address the quality of analysts' specific work in the individual development plans (IDPs) as they would for the QEPs, we believe the IDPs would be a reasonable substitute.

Agency's comments provided as text only.

Office of the Attorney General
Bill Lockyer, Attorney General
1300 I Street, Suite 1740
Sacramento, California 95814

August 12, 2003

Via Hand Delivery

Elaine M. Howle
State Auditor
Bureau of State Audits
555 Capitol Mall, Suite 300
Sacramento, CA 95814

RE: BSA Audit 2002-114: Department of Social Services Community Care: Response to Final Report

Dear Ms. Howle:

The Department of Justice (DOJ) has reviewed the Bureau of State Audit's (BSA) draft report to be issued on the Department of Social Services (DSS) Community Care Licensing Programs. On behalf of Attorney General Bill Lockyer, I am responding to your draft report as it applies to the Department of Justice and its process for distributing criminal history record information to DSS.

Recommendation 1:

- *The department and Justice should work together to identify what, if any, additional information such as convictions or diversions, the department may need to make reasonable and appropriate criminal history decisions after receiving arrest-only information. They should then arrange for Justice to provide the needed information.*

Response:

DOJ concurs with this recommendation in that DOJ has already begun discussions with DSS to determine the feasibility of supplying arrest disposition information to DSS, once this information is received by DOJ and updated to the Automated Criminal History System (ACHS). DOJ has provided DSS with an estimate of the initial cost associated with re-programming of the ACHS and related data bases, as well as a myriad of hardware modifications that would be required, and the ongoing costs associated with hardware maintenance and software support.

It is DOJ's understanding that DSS has submitted a Budget Change Proposal to request the required funding. Once DSS receives approval to proceed, DOJ will assemble a team to work with DSS to develop the specifications.

Recommendation 2:

- *Justice should continue to implement and further develop automated systems that not only increase criminal history reporting, but also ensure that reporting agencies submit arrest and disposition information more quickly and with fewer errors.*

Response:

DOJ concurs with this recommendation. The importance of complete and accurate criminal history record information cannot be overstated. As California's statutorily mandated repository of criminal offender records, the DOJ has long-recognized the impact that incomplete records have on our ability to provide timely and accurate information to those regulatory entities and criminal justice agencies who rely on this information in making decisions that impact the safety of the public. While statewide coordination of criminal record reporting poses some unique challenges, these challenges have not diminished our goal of achieving 100% compliance from reporting agencies. Over the last 4 years, with the support of local agencies and legislative leaders, DOJ has implemented a number of automation solutions to not only increase the overall reporting of arrest and disposition information, but also allow for information to be reported in a more efficient and timely manner. As a result, we have seen significant improvements in overall record quality, which allows us to provide the highest level of service possible to our clients.

While DOJ is committed to developing and implementing systems that promote and facilitate complete, accurate and timely reporting of criminal history information, full participation is dependent on the ability and/or willingness of each county or agency.

Thank you for this opportunity to comment on the BSA report. If you or your staff have any questions about this audit response, please contract Georgia Fong, Director, Office of Program Review and Audits, at (916) 324-8010.

Sincerely,

(Signed by: Steve Coony)

STEVE COONY
Chief Deputy Attorney General
Administration and Policy

Agency's comments provided as text only.

Human Services System
Children and Family Services Department, Fresno County
Gary D. Zomalt, Director
2011 Fresno Street, Suite #301
Fresno, California 93721

Elaine M. Howle, State Auditor
California State Auditor, Bureau of State Audits
555 Capitol Mall, Suite 300
Sacramento, California 95814

Dear Ms. Howle:

Enclosed for your review is our written response and uploaded report on the diskette provided, to "Chapter 3, Fresno and XXX Counties Generally Administered Their Programs Effectively Except for Complaint Processing" and "Fresno and XXX Counties Did Not Always Follow Required Complaint Procedures".

1. The licensing staff obtained additional training from Community Care Licensing (CCL) Legal staff on investigations in May 2003. We believe that this training will help reinforce the need for thorough documentation of cases throughout the investigation process.

2. Social Work Supervisor of Licensing met with the clerical support staff in June 2003, to review agency practice for always using the 1st day of the month as the official licensing action date on the license (documentation of training on file in licensing office).

3. Training for licensing was given by the Social Work Supervisor in Licensing to all staff in June 2003 regarding the confidentiality of criminal records and in particular the need to follow state regulations regarding transfer of such records (documentation of training on file in licensing office).

4. The department has submitted a request of CCL to clarify the regulation concerning medical clearances and to date has not received a response.

Sincerely,

(Signed by: CW for Dr. Gary Zomalt)

Dr. Gary Zomalt, Director

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Agency's comments provided as text only.

Human Services, Kern County
Beverly Beasley Johnson, JD, Director
100 E. California Avenue
P.O. Box 511
Bakersfiled, CA 93302

August 7, 2003

Elaine M. Howle, State Auditor
Bureau of State Audits
555 Capitol Mall, Suite 300
Sacramento, CA 95814

Dear Ms. Howle:

Thank you for the draft audit report regarding Kern County's Foster Care Licensing program. It appears from the audit report that overall Kern County's Licensing program is in compliance with Community Care Licensing policy and procedures.

Kern County's Licensing program will ensure compliance with both recommendations contained in the audit report. While Kern County does not necessarily agree with the findings in their totality, Kern County does desire to provide excellent services to ensure the safety of the children in our care. Therefore, all deficiencies uncovered during a licensing complaint investigation will be documented thoroughly and followed-up on in a timely basis to ensure compliance. Investigative outcomes will be reviewed with the State liaison and will be documented in the licensing file. Kern will anticipate further training on developing appropriate plans for corrective action to be provided by Community Care Licensing.

Sincerely,

(Signed by: Beverly Beasley Johnson)

Beverly Beasley Johnson
Director

cc: Members of the Legislature
Office of the Lieutenant Governor
Milton Marks Commission on California State Government Organization and Economy
Department of Finance
Attorney General
State Controller
State Treasurer
Legislative Analyst
Senate Office of Research
California Research Bureau
Capitol Press