

# DEPARTMENT OF SOCIAL SERVICES

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

REPORT NUMBER 2002-114, AUGUST 2003

Department of Social Services' response as of October 2003

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### ***Audit Highlights . . .***

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

- 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.*
  - Was not always timely, consistent, and thorough in its enforcement of legal decisions.*
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The Joint Legislative Audit Committee requested that we assess the Department of Social Services' (department) policies and practices for licensing and monitoring community care facilities. Since our last review in August 2000 (child care report), the department has more selectively granted criminal history exemptions and has prioritized and quickly processed legal actions against facility licensees. However, the department could improve in other areas.

### **Finding #1: The caregiver background check bureau granted exemptions without considering all available information.**

The caregiver background check bureau (CBCB) did not sufficiently consider information other than convictions when reviewing five of the 45 approvals we examined. The department's evaluator manual instructs the CBCB staff to consider factors such as the age of a 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. For example, the CBCB ignored self-disclosed crimes not appearing on individuals' criminal history records (rap sheets) and accepted without question character references that appeared inadequate.

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.

***Department Action: Partial corrective action taken.***

The department reported that it agrees with these recommendations. It has drafted procedures related to exemption processing, trained its staff on these procedures in September 2003, and will release an updated procedures manual in November 2003. The department reported that rap sheet screening procedures, among others, have been finalized and it is training staff on this material.

**Finding #2: The CBCB often did not perform criminal history checks within established time frames.**

The CBCB's performance in promptly communicating to facilities and individuals the ultimate decisions on exemption requests worsened since we issued the child care report, despite the CBCB extending its time frames for decisions from 45 days to 60 days. 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. 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.

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 making exemption decisions as requested.

***Department Action: Partial corrective action taken.***

The department said that it was placing a higher priority on individuals with lesser crimes or infractions because this group represents the largest majority of workload and allows these individuals to be in a facility as quickly as possible. The department stated that individuals needing a standard exemption will take longer to process.

**Finding #3: The CBCB's 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. 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. 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.

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.

***Department Action: Partial corrective action taken.***

The department stated that it is modifying its quality control procedures and expects final procedures to be in place by the end of 2003.

**Finding #4: The department could better track and assess arrest-only information and better review criminal history information before issuing clearances.**

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.

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 and 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.

In addition, 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. Without clear communication to track the status of a case, it is possible that after determining that an individual is unfit to be a caregiver, the department would fail to take action to remove the individual.

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. 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.

So that investigations of arrest-only information are properly tracked and communicated, we recommended that the department:

- Develop a process for the BIRS to record when it refers a case for investigation and track a case to make certain that an investigation takes place.
- Make certain 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.

We also recommended that the department review and enforce its arrest-only policies and procedures to ensure that it is issuing criminal history clearances only when appropriate to do so and properly train staff on these policies and procedures.

***Department Action: Corrective action taken.***

The department stated that it implemented a system that generates a listing of cases and the dates these cases are referred to the field for investigation. The department said the list will prompt its analysts to inquire about the status of case investigations. In addition, the department reported that it implemented procedures that clearly define the responsibilities for ensuring that an investigation has been completed and appropriate action taken. Finally, the department stated that it had implemented procedures that address clearance criteria for arrests and that all appropriate staff have been trained.

**Finding #5: The CBCB's handling of subsequent criminal history information was weak.**

The Department of Justice (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.

To ensure the department can account for all subraps it receives and that it processes this information promptly, we recommended that the department develop and implement a policy for recording a subrap's receipt and train staff on this policy. In addition, upon receiving a subrap, the department should ensure that staff meet established timeframes 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.

***Department Action: Partial corrective action taken.***

The department said that it has modified its computer system to allow for better subrap tracking. In addition, the department reported that all policies, procedures, and training plans will be in place by January 2004. Moreover, the department stated that it has placed a higher priority on cases where individuals have received approval to work in a facility and are later arrested for certain crimes or are

convicted of a crime. Finally, the department reported that it is reassessing its work priorities in order to establish more realistic timeframes regarding exemption needed notices.

**Finding #6: Under the CBCB’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 Community Care 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.

We recommended that the department 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.

***Department Action: Pending.***



The department assessed its practices as we recommended, but reported that limited resources will prohibit it from requiring additional Federal Bureau of Investigation background checks for individuals who become disassociated from a facility and then return to work within two years.

**Finding #7: The department did not always follow required complaint procedures.**

The department asserts that most of the corrective actions it undertakes are identified through its complaint process rather than other facility evaluations. However, we found when licensing analysts (analysts) identified facilities' deficiencies during complaint investigations, they did not always ensure that caregivers complied with the corrective action plans. 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. By not following through to see that corrections are made, the department negates its efforts in investigating and substantiating complaints.

To protect clients' welfare, laws and procedures mandate certain time frames within which the department must initiate and follow through on complaint investigations, but the department did not always meet these timeframes. For example, our review of 75 complaints the department received in calendar years 2001 and 2002 identified 19 complaints for which the department made its initial facility visits beyond the 10-day requirement set by law. The visits ranged from two to 175 days late. 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.

Finally, 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 because these complaints represent a serious threat to the clients' well-being. However, the department did not consistently follow these special procedures for the top-priority allegations among the 75 complaints we reviewed. For instance, the department did not refer two of 22 abuse 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. 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.

To address the department's weaknesses in following required complaint procedures, we recommended that the department:



- Continue to emphasize complaint investigations over other duties and require supervisors to review evidence that facilities took corrective action before signing off on a complaint.
- Require analysts to begin investigating complaints within 10 days of receiving complaints.
- Ensure that analysts follow policies requiring them to refer to the investigations unit any serious allegation within eight hours of receipt.

***Department Action: Partial corrective action taken.***

In August 2003, the department reminded its licensing staff of the importance of conducting and completing complaint investigations in a timely manner through a Workload Prioritization memorandum. The department reported that it will require all supervisors to wait to sign off on complaints until all plans of correction are complete. The department cited its increasing emphasis on complaints and the concern that all corrections be completed for making this change. The department indicated it plans to change its evaluator manual to reflect the requirement that licensing field staff issue a citation within 10 days of receipt of the investigative findings.

**Finding #8: 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). 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.

We recommended that the department require foster family agencies to ask each applicant whether he or she had uncorrected, substantiated complaints at any other foster family agency and to verify the accuracy of an applicant's statements with the applicant's immediate prior foster family agency.

***Department Action: Partial corrective action taken.***

The department reported that it is developing a self-assessment Technical Assistance Guide for foster family agencies and plans to finalize it by February 2004. In addition, the department stated that this guide will serve as the foundation for regulations that it will develop within a year.

**Finding #9: The department sometimes granted facility licenses based on incomplete applications and did not always perform required post-licensing visits.**

When making its decision to license a new facility, the department did 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. For example, 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. In addition, the department did not consistently conduct all necessary post-licensing evaluations or ensure that the visits it did perform were made within statutory timelines. Specifically, 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.

To ensure that it issues licenses only to qualified individuals, we recommended that the department ensure that analysts follow the department's checklist in collecting and considering all required licensing information, including, but not limited to, health screening reports, administrator's certification, and necessary background checks.

We also recommended that the department conduct the necessary post-licensing evaluations within the required time frame to make certain that newly licensed caregivers are operating according to regulations.

***Department Action: Partial corrective action taken.***

The department reported that it completed reviews of its licensing processes for its four program areas and is developing plans to better assure that all information necessary to approve licenses is received and reviewed. In September 2003, the department issued a memo outlining its program focus in response to the fiscal year 2003–04 budget. The memo lists post-licensing evaluations as an important activity and introduces annual and sample visit protocols that will provide additional time for post-licensing visits.

**Finding #10: The department did not always evaluate staff performance or provide required staff training.**

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. 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 analysts, she could not provide documentation to support her assertion. We believe ongoing assessment of the analysts' performance is essential to ensure the analysts are effectively applying program policies.

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. 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. Without the necessary ongoing training, we question whether analysts are prepared to effectively perform their duties.

We recommended that the department make certain that all licensing office supervisors conduct QEP reviews of their assigned analysts. In addition, we recommended that the department make available to analysts the necessary training and develop a method to track whether analysts are meeting statutory training requirements.

***Department Action: Partial corrective action taken.***



The department reported that it suspended its QEP evaluations in offices with severe staffing shortages and that it plans to reimplement these evaluations when staffing levels improve.

The department also stated that it had developed a new training database and instructed staff on its use. In addition, the department said it is developing a training need assessment tool to assist it in determining the specific needs of each licensing program.

**Finding #11: 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. Although the department reviews the counties' licensing programs, it provides limited guidance regarding time frames to department staff performing the reviews, for preparing their reports, notifying counties about deficiencies, and to provide counties to correct deficiencies. 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. 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.

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, we recommended that the department establish reasonable time frames for liaisons to prepare reports resulting from reviews of the counties and to notify counties of the results of those reviews and for counties to submit and complete their corrective action plans.

***Department Action: Corrective action taken.***

The department said that it developed a formal policy with timeframes for liaisons to prepare reports and send notification of the review results to the affected county. In addition, the department developed standard timeframes for staff to utilize in developing corrective action plans. This policy went into effect October 1, 2003.

**Finding #12: Despite recent efforts to improve, the department could do more to oversee county criminal history exemptions.**

There are 42 counties that contract with the department to license foster family homes, and these counties 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. Contracted counties must submit exemption reports each quarter, but the department did not fully utilize the reports. The department has not provided its staff guidance on when to review the reports, what to look for when they perform their reviews, and when to follow up. We believe collecting and reviewing the exemption reports on a continuous basis allows the department to track criminal record information from all 42 counties and make certain it is aware of all their exemption processing.

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

***Department Action: None.***



In its response, the department stated that it has continually reviewed its quarterly county exemption reporting process with the counties and licensing supervisors. However, the department has not addressed the need for it to establish internal procedures to ensure the information the counties submit is promptly and consistently reviewed.

**Finding #13: 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. We reviewed 26 legal actions which resulted in a caregiver's probation, exclusion, or license revocation. In 11 instances the department either did not adhere to its follow-up procedures to ensure the caregivers complied with the terms of the probation, revocation, or exclusion, or did not document its actions. Specifically, in five cases, the department failed to follow up with the caregiver promptly and in two cases did not visit the caregiver at all. In the remaining four cases, the department did not document the actions it took to follow up on the legal decision that was made.

To improve its enforcement of legal actions, we recommended that the department conduct follow-up visits to ensure that enforcement actions against facilities are carried out and that it document its follow-up for enforcement of revocation and exclusion cases.

***Department Action: Corrective action taken.***

The department stated that in August and September 2003 it issued memos reemphasizing the importance of conducting required visits to facilities to enforce legal actions.