Department of Social Services

In Rebuilding Its Child Care Program Oversight, the Department Needs to Improve Its Monitoring Efforts and Enforcement Actions

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Department of Social Services' responses as of May and August 2007

The Joint Legislative Audit Committee (audit committee) requested the Bureau of State Audits to review the Department of Social Services' (department) oversight of licensed child care facilities. Specifically, the audit committee requested that we assess the department's progress in meeting facility inspection requirements and determine whether the department's authority and resources were adequate to fully enforce the required health and safety standards in child care facilities. Additionally, we were asked to review the department's process for investigating and resolving complaints regarding facilities. Further, the audit committee asked us to examine the department's policies and procedures for categorizing health and safety risks identified at child care facilities and to review the reasonableness of the department's processes and practices for informing parents of problems it had identified. Finally, the audit committee requested that we review the disciplinary process the department uses when it identifies deficiencies in facilities.

Finding #1: The department has struggled with making periodic inspection visits required by statutes, and the data it uses to track these visits are not sufficiently reliable.

State law enacted in August 2003 established new requirements for how often the department should conduct periodic inspections of child care facilities. Under this new law, the department annually must make required visits to certain facilities and random visits to at least 10 percent of the remaining facilities. The requirements further state that the department must visit each child care facility at least once every five years, which means that it would conduct visits, on average, of approximately 20 percent of the facilities annually.

However, we found that the department did not meet those statutory requirements for fiscal year 2004–05, the only full year that had elapsed since the requirements were enacted. Specifically, the department performed 68 percent of the required or random visits needed for fiscal year 2004–05. In addition, these visits represented only 8.5 percent of the licensed child care facilities in the State during the same period.

Further, the department had yet to start tracking the "once every five years" requirement to determine the facilities it needs to visit so it can ensure that all are visited within the five-year period. Moreover, we found that the data the department uses to record and track inspection visits were not sufficiently reliable. For example, we found in the data numerous instances of multiple visits being made to the same facility on the same day. As a result of these and other problems, the data may not accurately reflect the department's progress toward meeting statutory requirements.

Audit Highlights . . .

Our review of the Department of Social Services' (department) oversight of licensed child care facilities found that the department:

- *Has struggled to make required visits to the facilities and carry out its other monitoring responsibilities.*
- *Began a three-phase effort in 2005 to rebuild its oversight activities for its licensing programs.*
- *Usually conducted complaint visits within established deadlines but did not always complete the investigations within deadlines.*
- *Did not always determine whether child care facilities corrected the deficiencies it identified during its visits to facilities.*
- *Could increase its use of civil penalties as a response to health and safety violations.*
- *Appropriately prioritized and generally ensured that legal cases were processed within expected time frames; however, its regional offices did not always adequately enforce legal actions against licensed child care facilities.*

We recommended that the department develop a plan to measure its random and required visits against its statutory requirement to visit each facility at least once every five years, assess its progress in meeting this and other statutory requirements, and ensure that the data it uses to assess its progress in meeting the various requirements are sufficiently reliable.

Department's Action: Partial corrective action taken.

The department has developed an information technology strategic plan to provide systems and tools to eliminate or mitigate problems identified in the audit, such as for measuring its random and required visits. The department stated its feasibility study related to the plan has been approved but that implementation of the plan is dependent upon funding. In the meantime, it is using interim solutions. In particular, it stated that it has developed special reports to identify child care facilities that have not received a visit and the number of facilities visited each year. In addition, the department stated that it has taken efforts to improve the accuracy of the data maintained in its systems. For example, the department completed a project that allowed automated field data to be electronically shared with its licensing information system. Finally, the department stated that it would continue its efforts to prevent any duplication of information.

Finding #2: Although the department has recently begun rebuilding its oversight operations, much more remains to be done.

In the spring of 2005 the department's community care licensing division initiated a significant effort to rebuild its operations in three phases. The rebuilding effort is intended to increase and improve the department's oversight of its licensing programs, including the child care program. The first two phases focused on rebuilding the "foundation" of the monitoring program, hiring staff, and increasing the department's monitoring and enforcement activities. At the time of our review, the department had yet to fully develop plans for Phase III, which it envisioned as a time to analyze the increased information it will have gathered and to determine any follow-up or modifications needed. However, as the department continues its rebuilding efforts, a question for the State's decision makers to consider is whether the level of monitoring that the department is working toward is sufficient to ensure the health and safety of children in child care facilities.

In addition, although the department has some existing methods and has started to implement others to help it monitor the activities of its regional offices, it has yet to develop the automated management information that will allow it to effectively perform this monitoring. Further, even though the department has established a process to inform parents of certain deficiencies it has identified at child care facilities, it has yet to make nonconfidential information about its monitoring visits to facilities readily available to the public. The department has expressed its intent to put all nonconfidential information on its Web site, but stated that implementation will be dependent on funding.

We recommended that the department continue its efforts to rebuild the oversight operations of its child care program and assess the sufficiency of its current monitoring efforts and statutory requirements to ensure the health and safety of children in child care facilities. In addition, the department should develop sufficient automated management information to facilitate the effective oversight of its child care program regional offices. Further, the department should continue its efforts to make all nonconfidential information about its monitoring visits more readily available to the public.

Department's Action: Partial corrective action taken.

As part of the department's efforts to ensure the health and safety of children in child care facilities, the department stated it contracted with the University of California, Davis (UCD) to conduct a nationwide literature review about the frequency of inspection visits, caseloads, and measures that reduce risk and increase safety. According to the department, the results of the review showed that the majority of the information provided to it involved descriptions of policies, procedures, opinions, and recommendations. The department reported that empirical studies are scarce

showing the effects of such policies, procedures, and recommendations on the health and safety of children. Although the department stated that information presented in the UCD report did not lend itself to comparison with practices in the State such as frequency of visits, it further stated its belief that the State appears to meet many of the standards that informed opinion considers to be beneficial in protecting the health and safety of children in child care. These standards include well-defined licensing requirements, background checks, and staff training and education requirements.

The department also reported that it intends to develop the necessary tools and management information to better assess its oversight responsibilities through its information technology strategic plan. (See Finding 1 for further discussion.) In addition, it stated that it accepted the recommendations of its performance review team about the use of data from one of its automated systems to facilitate quality reviews. The department further reported that its work team is identifying automated system information for use as quick performance indicators, developing procedures for electronic review of work, and designing formats for ongoing management reports to serve as routine performance indicators. Finally, the department stated its development and implementation of a web-based application to enhance public access to information depends on additional resources.

Finding #3: The department could improve its handling of complaint investigations.

Of the 40 complaint investigations we reviewed, the department completed eight outside its established 90-day deadline, ranging from 39 to 247 days late. In addition, our review of 54 complaint allegations the department deemed inconclusive revealed that in 19 instances it could have taken additional action to determine that the allegations were substantiated or unfounded. Further, we found little guidance in the department's evaluator manual about the actions the department should take in these instances. The department stated that its training in April 2006 was to include exercises designed to help new analysts evaluate evidence and reach conclusions on complaint allegations. At the time of our review, the department also planned to hold advanced complaint training for all child care licensing staff.

The department considers a complaint investigation complete when a supervisor approves the investigation. In six of its regional offices, the approval occurs after an analyst submits the investigation's findings but before corrective action is taken. The remaining six regional offices are taking part in a pilot project in which the approval occurs after the facility's plan of correction has been completed. However, the department has not yet determined which method of supervisory approval it intends to implement statewide.

Our review in one regional office of the department's complaint specialist pilot project, which it implemented in July 2005, disclosed several instances in which the department did not ensure that it took timely and appropriate action to enforce serious health and safety violations. For example, the department had taken follow-up action for only two of the seven facilities we reviewed since the complaint investigations were completed.

We recommended that the department complete complaint investigations within the established 90-day period, revise its policies to identify specific actions its child care program staff could take to reduce the number of inconclusive complaint findings, and continue its plans to train all of its analysts in evaluating evidence and reaching conclusions on complaint allegations. In addition, we recommended that the department evaluate its pilot project for supervisory approval after the plan of correction has been completed and implement a consistent process statewide for ensuring that licensees take appropriate corrective action. Further, the department should review the complaint specialist pilot project in its regional offices and use the results of its review to determine how it should modify its existing processes.

Department's Action: Partial corrective action taken.

The department reported that it implemented a new standard procedure in which monthly it identifies complaints that are pending over 90 days and makes a plan for their completion and closure. In addition, the department stated that it continued to review data on the findings of complaint investigations and found that about 30 percent were inconclusive. The department stated

that it is making modifications to its system to obtain more specific complaint data by regional office. The department also stated it will continue to study ways to reduce the number of inconclusive findings. Further, the department stated that all staff in its child care program have been trained in all facets of complaint investigations, including determining accurate findings. Moreover, in response to its pilot project regarding the timing of supervisory approval, the department issued a memo to standardize the process for reviewing and approving complaint investigations before the plan of correction has been issued. Finally, the department reported that it completed its complaint specialist pilot project and is in the process of incorporating pilot project practices into its permanent method of investigating serious complaints. However, the department encountered recruitment and retention issues among its complaint specialists and, as of August 2007, was soon to submit a request for a pay differential for these positions to the Department of Personnel Administration to address the issues.

Finding #4: The department did not always determine that facilities corrected deficiencies identified during its visits, and often its prescribed corrective action was not verifiable.

Our review found that the department did not always determine whether facilities had corrected the deficiencies arising from complaint, random, and required visits. For example, we found no evidence in the facility files that the department had determined whether deficiencies were corrected for 32 (25 percent) of 127 deficiencies the department cited from random and required visits. The department requires facilities to correct deficiencies within 30 days of being cited unless it determines that more time is needed. However, of the 95 deficiencies the department determined were corrected, we found that 31 were corrected more than 30 days after the department issued the citations. In addition, we identified various instances in which the plan of correction was not written in a way that the department could verify or measure the corrective action the facilities had agreed to take. Thus, the department did not always have ongoing assurance that the deficiencies had been corrected.

We recommended the department ensure that deficiencies identified during its monitoring visits are corrected within its established 30-day time frame, that evidence of corrective action is included in its facility files, and that required plans of correction submitted by facilities are written so that it can verify and measure the actions taken.

Department's Action: Corrective action taken.

The department developed extensive revisions to its evaluator manual, particularly regarding clearing deficiencies, granting extensions for plans of correction, and using self-certifications. The evaluator manual revisions also included guidelines for developing effective plans of correction. In addition, the department indicated that it trained its staff in these areas and that there has been an increase in supervisory involvement to ensure consistency.

Finding #5: The department could increase its use of civil penalties as an enforcement tool.

Our review found that the department could increase its use of civil penalties as a response to health and safety violations by child care centers (centers) and family child care homes (homes). In particular, we found that the department did not assess civil penalties against homes in many instances we reviewed because the regulations for homes prescribe a more limited use of civil penalties for violations than the regulations for centers do. Further, our review of selected centers and homes found that the department did not always assess civil penalties for repeat violations, even though laws and regulations require it. Moreover, the department's evaluator manual prohibits civil penalties from being assessed if a follow-up visit is not conducted within 10 working days of the date specified for corrections to be made. However, the department is not precluded from conducting subsequent visits to previously cited facilities and citing them for repeat violations of the same regulations within a 12-month period. Nevertheless, we found several instances in which the department might have assessed civil penalties but did not because it did not make any follow-up visits.

We recommended that the department ensure that it assesses civil penalties in all instances where state laws and regulations require it. Additionally, it should consider proposing statutes or regulations requiring it to assess civil penalties on homes for additional types of violations. Further, the department should consider seeking changes to the requirement that it cannot assess civil penalties if follow-up visits are not conducted within 10 days of the time that corrective action was taken.

Department's Action: Corrective action taken.

The department stated that it proposed a "zero tolerance" policy that was included in a bill that would require civil penalties to be assessed for certain high-risk violations. The bill was considered by the Legislature in 2006 but did not pass. Additionally, the department issued memos and distributed a civil penalty manual about the requirement and use of civil penalties as well as developed enhancements to the evaluator manual to further clarify the use of civil penalties. Further, the department concluded that the requirement is appropriate for follow-up visits to be made within 10 days of the plan of correction date in order for civil penalties to be assessed. Finally, the department stated that it may use progressive civil penalties to bring a licensee into compliance in the event that a follow-up visit is not made within 10 days.

Finding #6: The department has not consistently followed its guidance about using noncompliance conferences.

Our review of a sample of child care facilities at four regional offices revealed several instances in which the department did not follow guidance provided in a May 2004 memorandum about the use of noncompliance conferences to gain compliance from its licensees. For example, contrary to the May 2004 memorandum's requirements, the department did not require noncompliance conferences to be held after the initial citation for seven of 12 facilities we reviewed. In addition, we found that the department did not always conduct the noncompliance conferences promptly, given the severity of the noncompliance. In particular, the department took between two and five months to hold noncompliance conferences for five of 18 facilities we reviewed. Further, we identified instances in which the department's regional offices were inconsistent about the timing of noncompliance conferences. For example, one regional office required a licensee to attend a noncompliance conference 23 days after an incident occurred, whereas another regional office did not require a license to attend a noncompliance conference until nearly five months after an incident occurred.

We recommended that the department clarify its direction to regional office staff to help ensure that they are using noncompliance conferences promptly and in appropriate instances. Additionally, the department should reevaluate its May 2004 memorandum and, to the extent it reflects the department's current intent, incorporate the guidance into its evaluator manual. Further, the department should periodically review regional offices' use of noncompliance conferences to ensure that they are consistently following established policies.

Department's Action: Partial corrective action taken.

As of its latest response in August 2007, the department was in the process of revising the evaluator manual to incorporate the directives from its May 2004 memorandum and the recommendations from its internal review team.

Finding #7: The regional offices may not always consult legal staff as early as possible.

The department's evaluator manual states that situations involving physical or sexual abuse or ones in which there is an imminent risk to children should be referred immediately to the legal division. In addition, the manual states that regional offices should consult with their legal staff in cases in which the regional office is unsure as to whether legal action is warranted. However, we noted some cases that

caused us to question whether regional offices are consulting the legal division as early in the process as would be beneficial. The department acknowledged the need to use legal consultants more effectively by implementing in January 2006 a pilot project in Southern California to provide staff with more immediate access to legal consultants.

We recommended that the department ensure that regional office staff consult with legal division staff early in the process when circumstances warrant it by clarifying its policies as necessary and following up to determine that the policies are complied with.

Department's Action: Corrective action taken.

The department reported that the legal division's early consultation pilot project in Southern California was well received, yet significant operational changes were made because of staff turnover. It reevaluated areas of assignment and sent legal staff to regional offices to be readily available for consultation. However, the department stated that it was doubtful it would expand the pilot project to Northern California, in part because the diversion of legal counsel to full-time consultation did not seem likely. Still, the department stated that it has continued to stress the need for early legal consultation. Finally, the department indicated that it requires monthly legal consultation on all cases that may result in an administrative action.

Finding #8: The department's enforcement of legal actions continues to need improvement.

Our review of 28 legal cases—15 in which the facility's license was revoked and 13 in which facilities were placed on probation—found that regional offices did not always adequately enforce legal actions against licensed child care facilities. Specifically, we found that as of March 2006, the department had not made visits to 12 of the 15 facilities that had their licenses revoked, although it had been longer than the required 90 days in each instance. In addition, we found that the department did not make follow-up visits to two of the 13 facilities placed on probation.

The department's policies require it in some instances to exclude employees or adult residents from the facilities and require the regional office to verify at the next evaluation visit that the licensee is complying with the exclusion order. Three cases we reviewed required the department to exclude employees or adult residents from the facilities. In the three cases, the regional office did not promptly make visits to the facilities to ensure the licensee's compliance. For example, the regional office did not conduct a visit for one of the three cases until nearly a year after the exclusion order became effective.

We recommended that the department require follow-up monitoring visits to ensure that child care facilities with revoked licenses are not operating and that individuals excluded from facilities are not present in the facilities. In addition, we recommended that the department ensure that visits to facilities on probation are made within the required deadline. Further, the department should revise its policies for following up on excluded individuals to ensure that it more promptly verifies that they are not present in facilities.

Department's Action: Partial corrective action taken.

The department issued a memo in October 2006 that directed all licensing staff to consider follow-up visits to facilities with revoked licenses or those with excluded individuals as the highest priority work, equal to complaint visits. The memo also addressed instructions for ensuring that a facility is actually closed when revocation becomes effective, ensuring that an excluded person has actually left the facility, and monitoring visits to facilities on probation. In addition, the department indicated that it requested additional resources to minimize the impact on other licensing and monitoring activities. Further, the department stated that it was revising its evaluator manual to incorporate the mandates of the memo. Finally, the department stressed the importance of making enhancements to allow for automated tracking and notification for follow-up visits to facilities.