REPORT BY THE

AUDITOR GENERAL

OF CALIFORNIA

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Honorable Art Agnos, Chairman
Members, Joint Legislative
Audit Committee
State Capitol, Room 3151
Sacramento, California 95814

Dear Mr. Chairman and Members:

The Office of the Auditor General presents its report concerning the Department of Social Services' (department) monitoring of children's residential facilities that the department licenses. The department has not taken effective action against facilities that repeatedly fail to comply with licensing laws and regulations. Moreover, the department and agencies that place children in facilities do not coordinate monitoring of or share information about residential facilities. Finally, persons who have criminal records can work with children in the facilities for up to eight weeks or longer before their background is investigated. Because of these weaknesses, some children live in licensed facilities that are unsanitary and unsafe.

Respectfully submitted,

THOMAS W. HAYES
Auditor General

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SUMMARY

Some of California's licensed residential facilities for children are unsafe. The Department of Social Services (department) has not taken effective action to ensure that all facilities comply with state licensing laws and regulations. Moreover, the department and the agencies that place children in facilities do not coordinate monitoring of or share information about residential facilities. Finally, persons who have criminal records can work with children in the facilities for up to eight weeks before their background is investigated. Because of all these weaknesses, some children live in licensed facilities that are unsanitary, the department and placement agencies lack complete information about facilities, and children can be exposed to persons who have criminal backgrounds.

Failure To Require Compliance With Regulations

We reviewed files for 130 facilities in four of the department's ten district offices and found that the department has not taken effective administrative action against some facilities in spite of their repeated violation of licensing laws and regulations. Although the department can revoke or temporarily suspend a facility's license and can deny annual renewal of the license, the department is unable to take administrative action against facilities that repeatedly fail to comply with regulations if the department fails to conduct all the required annual inspections. In the four district offices, the department failed to conduct at least one annual inspection in 1983 or 1984 at 37 (28 percent) of 130 facilities in our sample. At 6 of these facilities, the department did not conduct the required annual inspections in both 1983 and 1984. In addition, the department does not always follow up to ensure that facilities correct deficiencies. In 1984, for example, an evaluator never returned to ensure that 3 facilities in Butte County corrected deficiencies that the evaluator

had identified. In Los Angeles County, evaluators failed to return to three group homes in 1984 to verify that the facilities corrected deficiencies. Finally, some of the department's inspections and investigations are not thorough and well-documented, and some evaluators failed to complete inspections.

As a result of these weaknesses, children lived in facilities that had broken and jagged glass in the windows and holes in the floors and walls. Department evaluators have also found facilities that had unsanitary kitchen facilities and insect-infested food. Failure to take effective administrative action against such facilities or to follow up to ensure that such conditions are corrected allows the conditions to persist.

These weaknesses have existed partly because the evaluators need to be better supervised. Department officials also noted a shortage in staff. In two of the districts we visited, the average caseload for evaluators exceeded the department's standards. Department officials indicated that the department hired additional evaluators during the last six months of 1984; some evaluators will be assigned to monitor residential facilities for children.

Failure To Coordinate Monitoring of Children's Facilities

Although the department is required to inspect the facilities only once a year, the majority of officers of agencies that place children in the facilities visit children they place in facilities within the county or in a contiguous county at least quarterly. During such visits, the placement officers identify circumstances that could jeopardize the safety of the children and that the facilities are required to report to the department. We compared records of such incidents reported in files of placement agencies with records in district offices and found that 79 percent of such incidents reported to placement officers during 1983 and 1984 were not recorded in the

department's files. Without such information from the placement agencies or the facilities and without more frequent monitoring by the department, the department is unable to take appropriate action against facilities.

Likewise, the department does not share information with placement agencies. Thirty-three percent of the placement agencies that reported problems to the department and that responded to our survey said that the department does not inform them about the resolution of problems that the placement agency reports to the department. Also, 43 percent of the placement agencies responding believed the department did not inform them regarding a facility's history of problems, and 62 percent said there was no communication regarding programs for children offered by particular facilities. Without information regarding problems at facilities or programs that facilities offer, placement agencies cannot be sure children are placed in facilities appropriate for their needs. For example, sex offenders placed in facilities sexually molested other children; the placement agency could not locate facilities that offered programs to treat the sex offenders' problems. At the time of our review, the department had not informed the placement agency that a nearby facility had a program to treat children who are sex offenders.

Failure To Prevent Persons Who
Have Prior Criminal Convictions From
Working in Children's Facilities

Although residential facilities for children must submit to the department fingerprints for all employees who work with children, department files lack evidence showing that the facilities are submitting all required fingerprints to the department. Moreover, the department has no routine procedures, except for its annual inspections, to identify facilities that do not comply with the regulations. During the two years covered by our review, the department had no evidence that it obtained the fingerprints for at

least one current employee in 32 of 130 facilities. Moreover, when the Department of Justice does not promptly provide information regarding the backgrounds of facility personnel, three of the four district offices we reviewed have no procedures to determine the reason for the delay.

Furthermore, even when facilities do submit all fingerprints as required and the Department of Social Services and the Department of Justice process them promptly, the system still does not prevent persons who have prior criminal convictions from working in children's facilities. State law permits persons to begin working in residential facilities for children before their backgrounds are investigated. We found that completing the investigation can take approximately eight weeks. During this period, persons who have criminal backgrounds worked with children without clearance from the department. Moreover, persons who resign from one facility when their criminal background is discovered can obtain employment at another facility and work with children there while the State conducts a new investigation.

Recommendations

To improve its regulation of residential facilities for children, the Department of Social Services should improve its supervision at the district offices and improve its processing and follow up of criminal record clearances. Moreover, the department should develop facility profiles so it can focus its resources on facilities that have frequent problems and develop and maintain on its information system a history of employees of residential facilities for children.

To improve coordination of monitoring by the department and placement agencies, the Legislature should require placement agencies to report violations of regulations to the department and require the department to maintain a history of facilities and to share this

information with placement agencies. Finally, the Legislature should require all small family homes and group homes to submit fingerprints of new staff when employees commence work at the facilities.

INTRODUCTION

In 1973, the Legislature enacted the California Community Care Facilities Act (act) to establish a coordinated and comprehensive system of providing quality nonmedical residential care for children and adults who need care and supervision. The act also includes care for persons who have mental disorders or who are developmentally and physically disabled. The intent of the act is to ensure that all persons in need of care and supervision are served by licensed community care facilities that are adequate, safe, and sanitary and that meet established health and safety standards.

The Community Care Licensing Division of the Department of Social Services (department) is responsible for licensing and regulating all community care facilities. Community care facilities include facilities such as adult day care facilities that provide nonmedical care for less than 24 hours a day and "residential facilities" that provide 24-hour nonmedical care and supervision. The department administers the program to license community care facilities through its ten district offices. The department, or any other agency authorized by the department to license facilities, processes applications for licensing of the facilities and must inspect the facilities at least once a year to determine if the facilities continue to comply with pertinent laws and regulations.*

*Counties license some community care facilities; this report, however, addresses small family and group homes for children that the department licenses and monitors.

Residential facilities for children include small family homes and group homes. In a small family home, the licensee provides 24-hour care for six or fewer children who are mentally disordered, developmentally disabled, or physically handicapped and who require special care and supervision as a result of such disabilities. Care is provided in the licensee's family residence.

A group home includes any facility of any capacity that provides 24-hour nonmedical care and supervision to children in a structured environment outside of the licensee's family residence. The licensee employs staff to provide all or part of the services. Although group homes can be licensed for six or fewer children, group homes are distinguished from small family homes in that the licensee resides outside the group home.

As of October 1984, 1,113 licensed small family homes were serving approximately 4,500 children throughout the State, and 1,102 licensed group homes were serving approximately 11,600 children. These 2,215 residential facilities for children represented approximately 7 percent of the 31,325 community care facilities of all types licensed by the State.

Licensing Procedures

Any person or group who intends to operate a residential facility for children must apply to the department for an operating

license. Before issuing a license, the department must review the facility to ensure that it is adequate, safe, and sanitary as required by the California Health and Safety Code. Furthermore, the department must review the criminal record of persons who will operate or work in the facility to determine if they meet the criteria of the Health and Safety Code. If the facility or its personnel do not meet the criteria, the department cannot issue the license.

Before issuing a license to operate a residential facility for children, the department must determine whether the applicants for the license and the employees who will work in the facility have ever been convicted of a crime other than a minor traffic violation. Facilities must submit fingerprints of the licensee and all staff who will have frequent and routine contact with the children. The department sends the fingerprints to the Department of Justice to determine if any of the persons have prior criminal convictions. The department refers to this process as a "criminal record clearance." Any person who has been convicted of a crime cannot work or reside in the facility unless the department determines that the person is rehabilitated and approves an exemption allowing the person to work in the facility.

Once a license has been issued, the department is required to evaluate the facility at least once a year to determine that it provides a safe and healthy environment for the children. If, during these evaluations, the department notes a deficiency--any failure to comply with the laws and regulations--the licensee must correct the deficiency within a specified time.

A deficiency can be serious or nonserious. Serious deficiencies are those that can result in an immediate or substantial threat to the health and safety of the children. For example, serious deficiencies include violations of regulations that pertain to the storage and preparation of food, violations of regulations that pertain to fire safety, and violations of regulations that pertain to the use of physical restraints on the children. Nonserious deficiencies are violations of any law or regulation that does not result in an immediate or substantial threat to the health and safety of the children. For example, if the department finds that a licensee needs to make some minor repairs and clean the facility, the department usually cites the facility for a nonserious deficiency.

When a facility does not correct a deficiency, the department's regulations require assessment of a civil penalty of $25 per day for one or more nonserious deficiencies or $50 per day for one or more serious deficiencies. The maximum total of civil penalties that can be levied for any deficiencies is $1,500, unless the evaluator cites the deficiencies again.

Generally, residential facilities for children must renew their licenses each year as specified by the Health and Safety Code. The department has the authority to deny an application to renew a license if the licensee is not in "substantial compliance" with licensing laws and regulations. Substantial compliance means that there is not an immediate and substantial threat to the health and safety of the children in the facility.

If a licensed facility fails to comply with the licensing laws and regulations, the department can initiate "administrative action" to protect the health and safety of the children. The department can deny renewal of a facility's license, can temporarily suspend the license, or can revoke the license. Before taking action to revoke or temporarily suspend a license, the department must file an "accusation," a legal notice that it intends to take administrative action against a facility.

Facilities can appeal the three administrative actions. A facility that appeals the denial of license renewal or revocation of the license can continue to operate until an administrative law judge decides the case. If the department temporarily suspends a facility's license, the facility cannot operate until the case is decided, and any children at the facility must be immediately relocated.

Placement Agencies

"Placement agencies" are agencies responsible for placing children in residential facilities that the department has licensed. Placement agencies include regional centers and county agencies. Regional centers are private agencies that contract with the Department of Developmental Services to provide services for developmentally disabled adults and children. County agencies are agencies such as the welfare department or the juvenile probation department. County welfare departments usually place abused, neglected, or abandoned

children who are dependents of the court; juvenile probation departments generally place delinquent children who are wards of the court. Most of the children who reside in residential facilities are placed by county welfare and juvenile probation departments.

Placement agencies are responsible for the care, treatment, and guidance given to children they place in residential facilities. State law requires the agencies to ensure that the facilities' programs will meet the particular needs of the children to be placed. Several placement agencies may have children at one facility. During periodic visits, employees of a placement agency (placement workers) monitor the progress of the child or children they have placed in the facilities. Placement agencies have no authority to require facilities to correct deficiencies in the facilities' physical plant or in the operating plans that facilities must submit to the department to obtain their licenses. However, placement agencies can report to the department incidents that could jeopardize the health and safety of children, and the agencies can remove any children they have placed in the facilities.

Program Funding

The department's Community Care Licensing Division is funded primarily from the State's General Fund. The budget for licensing community care facilities for fiscal year 1983-84 was approximately $26 million to cover the costs of licensing all types of facilities,

including day care for children and adults, residential facilities for the elderly, and residential facilities for adults and children.

County placement agencies such as county welfare and juvenile probation departments receive their funding through their counties. Regional centers are under contract to and are paid by the Department of Developmental Disabilities.

Previous Auditor General Report

The last Auditor General report on the State's residential facilities for children was published in 1980.* This report stated that the Department of Social Services had not effectively monitored the quality of care that children in these facilities receive. The report stated that facilities licensed by the State and the counties had not been adequately evaluated, civil penalties had not been assessed against facilities that violate laws and regulations, and complaint investigations were insufficiently documented and were not promptly conducted. Furthermore, the report revealed that the department had not determined if personnel in residential facilities had criminal records and that the department had not granted or denied exemptions for persons who had been convicted of a crime. (Appendix A summarizes the Auditor General's 1980 report.)

*This report is entitled "Improvements Warranted in Licensing of Residential Care Facilities for Children," Report P-003.1, September 1980.

SCOPE AND METHODOLOGY

We reviewed the Department of Social Services' program to inspect state-licensed residential facilities for children. We focused our review on the department's efforts to ensure that licensed facilities comply with the regulations designed to protect the health and safety of children placed in the facilities. We also reviewed the degree to which the department and placement agencies coordinate their monitoring of residential facilities for children and share information about the facilities. Finally, we reviewed the department's program for processing fingerprints of personnel in residential facilities; this program is intended to ensure that persons convicted of serious crimes are not allowed to work with children in the facilities. Our review generally covered two calendar years, 1983 and 1984.

In conducting our review, we selected a random sample of 130 files on residential facilities at four of the department's ten district offices: North Los Angeles, Riverside/San Bernardino, Sacramento, and South Los Angeles. We reviewed the files for small family homes and group homes to determine if the department conducted the required annual inspections, promptly followed up to ensure that facilities corrected deficiencies, and investigated completely the background of persons employed by facilities to work directly with the children.

We reviewed the files on residential facilities to determine if the residential facilities provided fingerprints for all personnel working in the facilities and if the department requested from the Department of Justice a report showing any criminal convictions of the personnel. We also determined if the department notified the residential facilities of personnel who had criminal records and if the department approved exemptions for those employees with criminal records. Finally, we reviewed the department's files to determine if facilities are located closer to other facilities than permitted by law.

In addition to our review of files at the district offices, we reviewed at six county placement agencies a sample of 219 case files for children whom the placement agencies had placed in residential facilities. We selected our sample from approximately 2,600 case files at the six placement agencies. The six placement agencies are located in Butte, Los Angeles, Riverside, Sacramento, and San Bernardino counties. These counties are in the areas covered by the four district offices we visited.

At the placement agencies, we reviewed the files to determine how often the placement workers visited residential facilities. We also attempted to determine the degree to which the placement agencies and the department coordinate monitoring of the residential facilities for children. From the agencies' files, we identified incidents that could jeopardize the health and safety of children at facilities. We

then examined department files on the facilities to determine if the placement agencies had notified the appropriate district offices of the incidents.

To determine if residential facilities report to the department incidents that jeopardize the health and safety of children in the facilities, we reviewed 46 children's records at six residential facilities: two facilities each in Butte and Los Angeles counties, and one each in Riverside and San Bernardino counties. We identified incidents that could jeopardize the health and safety of children in the facilities and examined the department's files on the facilities to determine if the facilities had notified the appropriate district office of the incidents.

Finally, to further determine the degree to which the department and placement agencies coordinate their monitoring of residential facilities for children, we sent questionnaires to county welfare departments and juvenile probation departments in all 58 counties in California. We received responses from 47 (81 percent) of the 58 welfare departments and from 46 (79 percent) of the 58 juvenile probation departments.

AUDIT RESULTS

I

THE DEPARTMENT OF SOCIAL SERVICES HAS NOT ALWAYS ENSURED THAT CHILDREN'S RESIDENTIAL FACILITIES COMPLY WITH STATE REGULATIONS

Some of California's licensed residential facilities for children are unsafe and unsanitary. Records of the Department of Social Services (department) indicate that children have been placed in residential facilities that have broken and jagged glass in windows, insufficient linens and clothing for children, and unsanitary kitchen facilities. Moreover, facilities have subjected children to procedures that violate state law. These conditions have persisted because the department has failed to take effective action against some facilities that repeatedly fail to comply with licensing laws and regulations. The department has not acted to suspend or revoke the licenses of some of the facilities that failed to comply with the regulations. In some cases, the department had renewed the facilities' licenses without first inspecting the facilities to ensure that they were safe. Also, the department has not always returned when necessary to follow up on facilities that it cited for deficiencies to ensure that the facilities corrected the deficiencies. Because of lack of follow up, the department was unable to assess civil penalties against facilities that may not have corrected deficiencies. In addition, some of the inspections that the department has conducted were not completed or were not thorough. Although, according to department officials, the

department has experienced some staff shortages in the past, the evaluators need to be better supervised to ensure they conduct thorough, well-documented investigations.

The Department Has Failed To Take Effective Action Against Facilities That Repeatedly Fail To Comply With Regulations

Some of California's residential facilities for children have repeatedly failed to comply with licensing requirements; in one instance, a group of facilities violated the same regulations several times over a ten-year period. The department's written policy is to take administrative action against facilities that repeatedly violate the regulations. As a result of the department's failure to always take effective action, some children were forced to live in surroundings that were unsafe or unhealthy.

Regulations for Safe Conditions

The department has established regulations designed to ensure that children in residential facilities receive quality care. Although facilities must comply with all the regulations, violation of some of the regulations are more serious than others because they present an immediate or substantial threat to the children in the facilities. For example, the following actions by facilities can subject children to potentially unsafe conditions: accepting more children than a facility's license allows; accepting nonambulatory children without

licensing approval; failure to obtain fire inspections by the State Fire Marshal; and failure to obtain and submit for investigation the fingerprints of a facility's employees. These conditions can subject children to physical danger or can expose children to persons who have prior criminal convictions.

In addition, facilities that violate the children's personal rights by humiliating or physically abusing children present a substantial threat to the children residing in the facilities. Moreover, facilities that improperly store and dispense medications or improperly store, prepare, and serve food can jeopardize the health and safety of children. The department considers violations of regulations that pertain to these actions as serious deficiencies.

Failure To Require Compliance With Regulations

Some licensed residential facilities for children repeatedly fail to comply with licensing regulations. For example, files for the 48 facilities in our sample in the Sacramento district office show that 6 of the facilities have been cited several times over several years for failure to comply with the same regulations. For example, one group home, which we refer to as Facility A, was licensed in July 1982. At the first inspection nine months later, the department cited the facility for not having fingerprints on file for most of its staff and for not maintaining adequate records of medication given to children. Both of these are serious deficiencies. In addition, the department

cited the facility for lack of records of monthly consultations between the psychiatrist and the children at the facility, for missing or incomplete employees' files, and for incomplete children's files.

The department's records indicate that the facility corrected the deficiencies cited in 1983. However, during its inspection in 1984, the department cited the facility again for failure to maintain records of monthly consultations between psychiatrists and children, for incomplete employees' files, and for incomplete children's files.

Another group home in the Sacramento district, Facility B, repeatedly failed to comply with numerous regulations several times during a ten-year period. Although our review generally covered calendar years 1983 and 1984, we found that in April 1973, a department evaluator observed that this facility was quite run down and poorly managed; the evaluator concluded that perhaps the children residing there should be placed at another facility. The evaluator found that the children's records lacked progress notes, legal authorization for admission to the facility, and diagnosis of the children's needs. In addition, the facility was operating without a license and had been doing so for nearly one year, from May 1972 to April 1973. Generally, the facility, its furnishings, and equipment were dirty and in bad condition, including broken window panes with jagged glass.

As a result of another visit in April 1973, the evaluator recommended that the facility's license be denied. The evaluator's

recommendation notwithstanding, the department issued the facility a license on November 20, 1973, and has continued to renew the facility's license each year since then.

In 1982, the department cited the facility for failure to have fingerprints on file for five employees and for failure to maintain complete employee records. The facility also employed staff who did not have first aid training, and the facility had no maintenance records on its van and no driving record for the van's driver. In addition, the facility had not completed and signed documents outlining the personal rights of the children. Finally, the facility was not in good repair: a closet door panel was pushed out, a window screen was missing, the carpet needed to be repaired or replaced, a door was off its hinges, and some of the walls had holes in them.

In 1983, the department again cited Facility B for six deficiencies that the department had cited the facility for previously. The facility was again not in good repair: five mattresses were worn and sagging, two boxsprings were missing, the bathroom floor had holes in it, the shower head was broken, and window screens were missing. The department again cited the facility because it had not prepared and signed documents outlining the personal rights for four children and because four employees did not have first aid training. Furthermore, the facility had no driving records for two employees and had no fingerprints on file for five employees.

In 1984, the department cited Facility B for the third time for not having fingerprint records on file and for not requiring first aid training for four employees. Furthermore, numerous bedframes, mattresses, boxsprings, and dressers needed repair or replacement. It appears to us that the licensee of Facility B is either unwilling or unable to comply with the regulations designed to ensure the health and safety of children placed at this facility. In spite of the facility's repeated violations of the regulations, however, the department has not taken administrative action against Facility B, and the department has renewed the facility's license through March 1986.

In its 1983-84 budget analysis, the Legislative Analyst reported that the department's annual inspection of facilities is not effective; the Legislative Analyst observed that the department has filed few "accusations" as a result of annual inspections. (An accusation is the legal notice that the department intends to take administrative action against a facility.) Our review indicates that the department does not always file accusations against small family and group homes regardless of how serious the deficiencies are, how many serious deficiencies are found, or how many times the department cites the facility for the same serious deficiencies. One of the department's branch chiefs we interviewed told us that the department will not submit cases for administrative action unless it believes it has sufficient evidence to win the case.

The facilities in Sacramento County are not the only facilities that the department has allowed to operate in spite of repeated serious deficiencies. In Butte County, for example, a licensee operates four group homes, all of which are supervised by the same administrator. We refer to these four homes as Facility C-1, C-2, C-3, and C-4, respectively. Although these four group homes have repeatedly failed to comply with the regulations, the department took no administrative action against them until after we selected facilities in Butte County for our review. Facility C-1 was initially licensed in 1973, Facility C-2 in 1977, Facility C-3 in 1980, and Facility C-4 in 1982. The department has cited these four facilities for violations of numerous regulations. In 1984, the department cited Facility C-2 for not having a maintenance person to do the necessary repair work. In 1983, the department identified the same problem at Facility C-1. In response to a complaint, the department cited the facility for not having sufficient staff for preparing meals and maintaining the facility.

In addition, the facilities violated state regulations in their treatment of children. The violations included violating the children's personal rights, including the right to wear their own clothing. For example, the facilities required children who ran away and returned to the facility to wear pajamas continuously for up to three weeks while at the facility. According to the facilities' description of their program (program statement) issued in 1977, a child's decision to return to the facility and to wear pajamas was seen

as "a voluntary act" to demonstrate the child's commitment to the facility's program. As such, the child's decision "does not deny the person her rights." The program statement added that the child "requesting readmission voluntarily waives this right [to wear her own clothes] as agreed for a specified length of time."

In June 1978, however, the department notified the facilities by certified mail that requiring children to wear pajamas in this manner violated state regulations and that the facilities should formulate a plan of correction within two weeks. In spite of this notification, the facilities continued this method of punishing children. In 1983, for instance, one of the facilities required two girls who ran away and returned to the facility to wear pajamas. When one of the girls refused, a male staff person held her and directed the other girls to take off her clothes and put pajamas on the girl. Subsequently, a county probation department official confirmed this incident.

These facilities also violated state regulations pertaining to a procedure referred to as "holdings." According to the facilities' program statement, a holding is "a procedure utilized to facilitate the safe expression of negative feelings and to prevent the person from hurting themselves [sic], or others, or property." One person physically holds a child's arms across the child's chest; other persons may hold the child's legs and body.

"Holdings," however, violate state regulations that prohibit any kind of physical restraint of children except in emergency situations. The department has cited at least one of the four facilities in 1982, 1983, and 1984 for holding children. In response to complaints, the department cited the facilities for holding or allowing other children to assist in holding children in February 1982, June 1983, and April 1984. During the department's investigation of the June 1983 complaint, one of the children told the evaluator that a 14-year-old girl was held. Another child verified this fact and further reported that the staff and children clamped shut the 14-year-old's mouth until it bled. The administrator of the facilities told the department that the 14-year-old child was held as a "last resort intervention" when the child became violent, and he said that his policy would be "absolutely no holdings as a treatment process." The department cited one facility again in April 1984 for "holding restraints being used by staff with residents assisting."

The four facilities in Butte County were also cited for other serious violations. For example, in February 1984, the department, in response to a complaint, cited Facility C-2 for its failure to report a serious incident to either the department or the child's placement worker. On two occasions, a child at this facility attempted to commit suicide. In addition to not reporting these two suicide attempts, the facility provided no psychiatric help to the child before or after the suicide attempts.

The department's files on these four facilities show a pattern of continual violation of state regulations during 1982, 1983, and 1984. Table 1 shows the number of times since 1982 that the department cited the four facilities for a serious deficiency.

TABLE 1

CITATIONS FOR SERIOUS DEFICIENCIES AT FOUR GROUP HOMES IN BUTTE COUNTY 1982, 1983, AND 1984

Deficiency	Dates Cited	Facility
No fingerprints submitted for new employees	February 4, 1982	C-2
	April 25, 1984	C-2
Medication not safeguarded	September 27, 1984	C-2
	October 4, 1984	C-1
	October 4, 1984	C-3
Children improperly supervised	April 25, 1984	C-2
	August 15, 1984	C-4
	October 10, 1984	C-2
	October 17, 1984	C-2
Food supply inadequate, not stored properly	July 29, 1983	C-4
	August 12, 1983	C-2
	August 15, 1984	C-4
	September 27, 1984	C-2
	October 10, 1984	C-2
Facility over capacity	September 12, 1982	C-3
	February 4, 1984	C-2
Children's allowances withheld as punishment	February 4, 1982	C-2
Failure to report two suicide attempts to department or placement agency and failure to provide psychiatric care	February 8, 1984	C-2

In addition to the serious deficiencies listed above, the department also cited the facilities at least 18 times for failure to keep the facilities clean and in good repair. Furthermore, the department cited the facilities on at least 6 occasions for having incomplete client records and 4 times for having staff who did not have first aid training. However, not until October 1984 did the department take administrative action against these facilities. In October 1984, after we began our review, the department denied the renewal of the licenses of three of the facilities. The license of the other facility does not expire until August 1985.*

Although the department denied renewal of the licenses for three facilities, in several respects this action is the least restrictive of the three administrative actions that the department could have taken against the facilities. For example, denial of the renewal of a license can occur only at the time the license expires. Facilities that violate regulations can continue to operate until their applications for license renewal are denied. Furthermore, denying renewal of the licenses allows the facilities, if they appeal the action, to continue operating until an administrative hearing is held and an administrative law judge renders a decision. In addition, even if the administrative law judge upholds the denials, the licensee can apply for a new license, and the department must process the application.

*The department filed a Statement of Facts in January 1985 that recommended revoking the license of the fourth facility.

In contrast, if the department had revoked the facilities' licenses, the licensee could continue to operate while the action is appealed, but the department could not consider for at least two years the licensee's application for a new license if the administrative law judge upheld the department's revocation. And if the department had temporarily suspended the facilities' licenses, the facilities would have had to cease operations immediately, and all children would have been placed in other facilities.

The Department Has Failed To Conduct Timely and Proper Inspections and Has Not Followed Up To Ensure That Facilities Correct Deficiencies

The department cannot act against facilities that may repeatedly fail to comply with regulations because of the department's failure to conduct annual inspections as required and to follow up to ensure that facilities corrected deficiencies. Furthermore, some of the department's inspections of facilities or investigations of complaints have not contained thorough and well-documented evaluations.

Failure To Conduct Annual Inspections

State law requires the department to inspect and evaluate facilities at least once a year and as frequently as necessary to ensure that children live in facilities that are safe and sanitary. We found, however, that the department has not always conducted annual

evaluations before renewing facilities' licenses. We reviewed the files of 130 facilities and found that for 37 (28 percent) of the facilities, the department failed to conduct at least one annual evaluation during 1983 or 1984. In 1983, the department failed to inspect 22 (17 percent) of the 130 facilities; in 1984, the department failed to inspect 21 (16 percent) of the 130 facilities. Moreover, the department failed to inspect 6 of these facilities in both 1983 and 1984.

In the North Los Angeles district office, evaluators failed to conduct at least one inspection during 1983 or 1984 at 9 (56 percent) of the 16 facilities we reviewed, and in the South Los Angeles district office, the evaluators missed at least one inspection at 4 (17 percent) of the 24 facilities we reviewed. Furthermore, for two consecutive years, the department failed to inspect one of these facilities in the South Los Angeles district office. One small family home in the South Los Angeles district that was not inspected in 1983 was cited in 1984 for not having medical clearances or criminal record clearances on file for two employees. An evaluator had also cited this facility in 1982 for not having all the necessary criminal record clearances. Because the department did not inspect this facility in 1983, the department does not know whether this facility violated this regulation for three consecutive years.

In the Riverside/San Bernardino district office, the evaluators failed to conduct at least one annual inspection at 21

(53 percent) of 40 facilities during 1983 or 1984. At one facility in the Riverside/San Bernardino district, the department did not conduct a renewal evaluation for nearly six years--from September 1979 until October 1984. Two Los Angeles County placement agencies had also investigated this facility in 1979.

During its investigation in July 1979, the Los Angeles County Department of Public Social Services reported that the facility's general philosophy and program appeared to contain elements of "cultism." The Los Angeles County Probation Department investigated the facility in September 1979, accompanied by an evaluator from the department, and confirmed the cult-like characteristics of the facility's program, including alienation of the children from the outside world. The evaluator cited the facility for not allowing the children to leave the facility or use community resources during an initial "isolation period" that lasted up to three months. In addition, the evaluator cited the facility for not allowing the children access to a telephone to make or receive calls and for not allowing the children to receive mail or receive visits at the facility from their families during the isolation period.

In spite of the conditions it found in 1979, however, the department did not conduct the annual evaluation of this facility from 1979 until 1984. Consequently, the department could not be sure that the facility was providing a safe and healthy environment for children

during that time. Nevertheless, the department, without conducting annual inspections, continued to renew this facility's license each year since 1979.

Failure To Conduct
Follow-Up Inspections

In addition to not conducting all required annual inspections, the department has not always followed up to ensure that facilities correct deficiencies that the department identifies. When a department evaluator determines that a deficiency exists at a facility, the evaluator must issue in writing a notice of deficiency. The notice of deficiency must cite the statute or regulation that has been violated, describe how the licensee failed to comply with a specific law or regulation, and state precisely where in the facility the deficiency occurred. The notice of deficiency must also include a plan for correcting the deficiency and a date by which each deficiency shall be corrected; that date must not be more than 30 calendar days after the notice of deficiency is served unless the deficiency cannot be completely corrected within 30 days. In those cases, the evaluator must specify the intermediate corrections that must be taken within 30 days.

Within ten days after the date the deficiencies should be corrected, the evaluator must reinspect the facility to determine if the facility has made the necessary corrections. This follow-up inspection is not required if the facility has otherwise demonstrated

that the deficiencies have been corrected. If the follow-up inspection shows that the facility has not made the corrections, the evaluator must levy civil penalties of up to $50 per day against the facility, beginning from the date the corrections were supposed to be completed until the date they are corrected. If, however, the inspector does not return within ten days after the date the deficiencies are to be corrected, the department forfeits its right to assess civil penalties.

We found that the department does not always return to facilities on time to ensure that facilities correct violations. We reviewed the files of 13 small family homes in Butte County. In 1984, the department cited 8 of these homes for deficiencies; however, it failed to return to 3 (38 percent) facilities to ensure that the violations had been corrected. At one small family home, the evaluator cited the facility for a number of violations, including a serious violation--the home did not maintain medication safely. The evaluator directed the facility to correct the serious violation within five days or incur a $50 per day civil penalty. However, the evaluator did not return to the facility to determine if the violation was corrected. Because the evaluator did not return to the facility within ten days after the deficiency was to be corrected, the department lost its right to levy a penalty. The department renewed the facility's license in October 1984 without verifying that the violations had been corrected.

We reviewed files for seven group homes licensed by the South Los Angeles district office. Although in 1984 the department cited

four facilities for deficiencies, the department failed to return to three (75 percent) of the four facilities to ensure that the facilities had corrected the deficiencies. Two of these three facilities were cited for not having a sufficient supply of perishable foods. In addition, the department cited one facility for not having enough linens, and all three facilities needed repairs and maintenance. Yet, the department renewed the licenses of all three facilities without ever returning to the facilities to verify that the deficiencies had been corrected. By failing to return to the facilities, the department could not be sure that the facilities had corrected the deficiencies, and it could not levy any civil penalties that were warranted.

If the department does not conduct periodic inspections and does not follow up to ensure that deficiencies are corrected, it cannot become aware of unsafe conditions in facilities unless someone files a complaint against a facility or reports an incident that jeopardizes the health or safety of children. The department believes that parents of the children residing in the facilities should become more involved in monitoring the facilities. The chief of one of the department's field operations branches agreed, however, that since most children in residential facilities are placed there because they have been abused or neglected by their parents or have gotten in trouble, it is not reasonable for the department to rely on the children's parents to provide information regarding deficiencies at the facilities. The branch chief said the department would have to rely on placement agencies to provide information to the department. Furthermore, as we

discuss later in this report, the department has not always used the information it receives from nondepartment sources to enhance its oversight of facilities.

The department could, however, use information from its inspections and investigations of complaints, as well as information it receives from placement agencies and the facilities, to develop a "history" of the residential facilities. The department could then devote more of its time and resources to facilities that present many problems and less resources to facilities that present few or no problems.

Failure To Conduct Complete and Thorough Inspections

In addition to not conducting annual inspections as required and failing to follow up to ensure that facilities correct deficiencies, the department does not always conduct complete and thorough inspections. As a result, facilities that violate regulations may continue to operate unsafe and unsanitary facilities.

Department evaluators have sometimes failed to complete investigations of complaints. For example, in October 1984, a placement agency filed a complaint against a facility in the Riverside/San Bernardino district. The complainant alleged that the licensee provided a pay telephone in one of its group homes but required the houseparents to provide their own telephone if they

desired additional telephone service. The complainant also alleged that social workers and child care staff at the facility were not qualified and that the licensee moved children from one facility to another facility without approval of the children's placement agencies.

The evaluator investigated the complaint within the time specified by law, substantiated parts of the complaint, and completed a report. The report indicated that the complaint was partially substantiated "pending completion of investigation with [the facility's program director]." We requested a copy of the final report on this investigation and found that the evaluator had failed to complete the investigation as of January 1985.

In another district office, documents of a complaint investigation also showed that the investigation was neither complete nor thorough. The report of the investigation indicated that the investigation could not be completed until the evaluator contacted the facility administrator. Two months after the date of the report, the evaluator still had not completed the investigation. In addition, the evaluator failed to thoroughly investigate the complaint. Although the evaluator made the required visit to the facility to investigate the allegations and recorded the information provided by the houseparents present at the facility, the evaluator failed to ask key questions that would have permitted her to properly document the case and reach a conclusion on parts of the complaint on which there was no conclusion.

Another example also illustrates the department's lack of thorough action during an inspection. The department licensed a facility in August 1983. In October 1984, the department received a complaint about the facility, and the evaluator made one visit during which he conducted the annual inspection and investigated the complaint. During the visit, the evaluator substantiated the complaint that the facility was providing a type of care that was not permitted under the facility's license. In addition, the evaluator noted that the facility was dirty and that broken toys, equipment, and furnishings presented hazards to the children. The evaluator also determined that the licensee was not properly supervising the children.

The evaluator could have cited the facility for deficiencies, completed a plan of correction, conducted a follow-up visit, levied civil penalties, or recommended administrative action against this licensee. However, while the evaluator was completing his visit, the licensee informed the evaluator that she would relinquish her small family home license (issued by the State) because she was applying for a foster home license (issued by San Bernardino County). Later, the evaluator advised the licensee by certified mail that he had substantiated the allegations in the complaint. He also restated the licensee's desire to relinquish her license, acknowledged receipt of her license, and advised her that her facility was, therefore, no longer licensed.

Children were still living in the facility, however, and because the evaluator accepted the license, the department lost its authority to conduct a follow-up visit, levy civil penalties, or recommend administrative action against the licensee. Furthermore, if the licensee in this case applies for a new license and the facility meets the licensing requirements, the department would have to process the application even though the facility, when it was licensed, failed to comply with the regulations.

The Department's Failure To Take Action Forces Children To Live in Unsafe Conditions

Because the department has failed to take effective action against facilities that repeatedly fail to comply with regulations and has not conducted timely and thorough inspections, children have been forced to live in unsafe and unsanitary surroundings. In September 1984, an evaluator reported that the food at Facility C-2 included "spoiled vegetables with maggots." Food was stored under the sink in open, leaking containers, and insects were living in these containers. There were numerous flying insects and spiders in the food storage bin. Cornmeal bags had an extreme odor of spoiled food. The evaluators confiscated as evidence cornmeal containing living insects and worm-infested macaroni. Facility C-2 also had broken windows with jagged glass and malfunctioning toilet facilities that allowed waste matter to accumulate in the toilets.

Although two evaluators visited this facility and documented their findings with photographs, the department did not initiate administrative action to temporarily suspend the facility's license. A temporary suspension would have forced the facility to cease operations immediately and would have required placement agencies or responsible persons to move the children to other locations. Because the facility's license was about to expire, however, the department simply denied the renewal of the facility's license.

The facility appealed the department's action, which permitted the facility to continue operating until the department scheduled an administrative hearing and obtained a decision on its denial of the license renewal. As of March 1985, the department had not received a decision on its denial of the license renewal. Until a decision on the denial is reached, children may continue to live in unsafe, unhealthy, and unsanitary conditions.

The Department Has Staff Shortages and Needs Better Supervision

According to two district managers, district offices experienced staff shortages in 1983 and 1984. One of the branch chiefs told us that during the last six months of 1984, however, the department hired approximately 100 evaluators statewide to monitor all types of facilities that the department licenses. Although the recently hired evaluators will provide additional resources for the department, evaluators need to be better supervised to ensure that the department effectively monitors residential facilities for children.

Staff Shortages

Managers in two of the department's four district offices that we visited told us they experienced staff shortages in 1983 and 1984. The department's standards for monitoring residential facilities for children provide one evaluator for 124 small family homes or 73 group homes. According to the chief of the department's Data Systems Unit, the department has no standards for evaluators whose caseload includes different types of facilities, and the standards do not allow for variations in travel time to reach facilities.

The average caseloads of the department's evaluators in the district offices we visited exceed the department's standards. For example, according to the district manager of the Sacramento district office, the office had 32 evaluators as of February 1985, 4 of whom were hired after September 1984. These evaluators monitor all state-licensed facilities in the entire district, which includes 26 counties. The district ranges from Mariposa and Merced counties on the south to the Oregon border on the north, and from the coastal mountain range on the west to the Nevada state line on the east.

Because the district covers such a large geographical area, the Sacramento district office assigns evaluators responsibility for monitoring both day care and residential facilities for adults and

children.* There are 4,160 state-licensed facilities within the Sacramento district, or an average caseload of 130 facilities per evaluator. The average caseload per evaluator exceeds the standards for both group homes and small family homes for children.

According to the district manager of the South Los Angeles district office, the office had 20 authorized evaluator positions in January 1984; 17 positions were filled. In September 1984, the South Los Angeles district office was authorized 3 additional evaluator positions, for a total of 23 authorized positions. Only 16 positions were filled, however. During September 1984, the South Los Angeles district included more than 2,550 licensed facilities, an average of approximately 159 facilities per evaluator. This caseload exceeds the department's standard for small family homes and group homes for children. The North Los Angeles and the Riverside/San Bernardino district offices experienced similar staffing problems.

The evaluators have many responsibilities in addition to processing license applications, conducting the ongoing monitoring and reinspections of facilities cited for deficiencies, and investigating routine complaints. Evaluators are sometimes required to conduct orientations for persons interested in applying for a license and to respond to requests for information.

*As of January 1, 1985, the law required the department to separate licensing of day care facilities for children from other types of facilities licensed by the department.

In addition, although the department has a special unit trained to investigate incidents of physical or sexual abuse, evaluators in the district offices often have to conduct these investigations. The Office of Audits and Investigations within the department's Community Care Licensing Division is staffed with personnel especially trained to investigate complaints of physical and sexual abuse. The chief of this office told us, however, that his office is unable to handle all of the abuse complaints because he has only 16 investigators to investigate an average of about 50 abuse complaints per month for the entire State. When the Office of Audits and Investigations does not have anyone available to investigate an abuse complaint, a district office evaluator must conduct the investigation.

According to the chief of the department's southern field operations branch, during the last six months of 1984, the department hired approximately 100 evaluators throughout the State to monitor all types of facilities licensed by the department. The deputy director of the department told us that the department hired many of these employees to fill vacancies in all areas. However, some of the evaluators will be assigned to monitor small family and group homes for children.

Need for Supervision

Department evaluators need to be better supervised to ensure that the evaluators conduct effective, thorough, and well-documented evaluations of residential facilities. In some district offices, supervisors were not aware of incomplete inspections. For example, one evaluator noted in the files of two of the facilities in our sample that he could not review the employees' and children's files during his annual inspection of the facilities and that he would return later to complete his review of the files; however, he never completed these reviews. This evaluator's supervisor was not aware that the evaluator had never completed the annual inspection of these two facilities.

In the investigation mentioned earlier in which the evaluator failed to ask key questions that would have permitted her to properly document the case and reach complete conclusions, better supervision would have improved the evaluator's performance. After our review focused attention on this investigation, the evaluator's supervisor pointed out to the evaluator some of the questions the evaluator failed to ask.

II

THE DEPARTMENT AND PLACEMENT AGENCIES DO NOT COORDINATE MONITORING OF CHILDREN'S RESIDENTIAL FACILITIES

The Department of Social Services and the placement agencies do not coordinate their monitoring of residential facilities for children. Placement agencies do not always report to the department incidents that jeopardize the health and safety of children, and the department does not always respond to placement agencies that do report incidents. In addition, the department does not always provide placement agencies with information about the background of facilities or information the department should have on file about programs offered by the facilities. Because the department and the placement agencies do not share such information, the department's monitoring efforts are hindered, and placement agencies may place children in facilities that are unsafe or do not provide specific services needed by some of the children.

Placement Agencies Do Not Provide Information to the Department

Although some placement workers visit children at residential facilities as frequently as once a month and are aware of incidents that could jeopardize the health and safety of children, placement agencies do not always report these incidents to the department.

Frequent Visits to Facilities

Although the department must inspect residential facilities for children only once a year, placement workers may visit children in these facilities as frequently as once a month. In our survey of county welfare departments and juvenile probation departments, we asked how often their workers visited children at facilities. Ninety-eight percent of the agencies that responded reported that their workers visit at least quarterly those children placed within their counties. Further, 88 percent of the agencies responding said their workers visit children the agencies placed outside their counties at least quarterly.

In addition to surveying placement agencies, we examined children's files at the placement agencies we visited. During this review, we found that placement workers visited 58 percent of the children at the facilities at least quarterly. These children were placed, for the most part, either within each placement agency's county or in an adjacent county. We were unable to determine how often placement workers visited an additional 38 percent of these children partly because the placement workers did not record all of their visits or because the children were briefly or recently placed in the facilities.

Although state law does not require placement agencies to monitor residential facilities, placement workers are required to periodically contact the children that the agencies have placed in the

facilities. State regulations require social workers in county welfare departments to meet at least quarterly with children placed in facilities; county probation officers must visit the children at least once every six months. Placement workers commonly meet the children at the facilities in which the children are placed.

Because placement workers visit the facilities more frequently than the department's evaluators do, placement agencies have more opportunities to monitor the children's health, safety, and welfare. In our questionnaire, we asked placement agencies if, during visits to facilities, their workers could observe possible violations of licensing regulations. We specified 19 areas in which deficiencies could jeopardize children's health, safety, and welfare. The areas we selected are among those that the department's evaluators review during their annual inspections of facilities. For example, we asked placement workers if they could provide information concerning death or injury to children or could report situations in which children are experiencing physical, mental, or verbal abuse. (Appendix B lists the 19 areas.)

At least 52 percent of the placement agencies responding to our questionnaire indicated they could report deficiencies in all 19 areas. At least 70 percent of the agencies responding said that their workers could report deficiencies in 15 of the 19 areas. We also asked the placement agencies if they could report these deficiencies on a standard checklist. At least 78 percent of the placement agencies

indicated that they could and would use such a checklist to report deficiencies in the 19 areas if a checklist were available.

Failure of Placement Agencies and Facilities To Notify the Department About Serious Incidents

The California Administrative Code requires facilities to notify both the department and the placement agencies of all incidents that could jeopardize the health and safety of children. For example, the facilities must report to the department the death of a child, any injury requiring medical treatment, any suspected physical or psychological abuse of a child, or any unusual incident that could threaten the physical or emotional health or safety of a child. However, neither the placement agencies nor the facilities are reporting all such incidents to the department.

Although placement agencies identify deficiencies during their visits to facilities and the facilities notify placement agencies of incidents that could jeopardize the health and safety of the children in those facilities, placement agencies do not always share this information with the department. During our review of children's files at the placement agencies, we identified 116 incidents that jeopardized the health and safety of children. However, we were able to find a record of only 24 (21 percent) of these incidents in the facility files at the department's district offices.

Several of the incidents that we could not find recorded in the department's files involved physical or sexual abuse. One incident involved a child who alleged that she had been sexually molested by an employee at the facility. In another incident, a child was in fact physically abused by the houseparent of a group home, and in other cases, children were either physically or sexually abused by other children at the facilities.

Other types of incidents that were not recorded in the department's files include the following: children running away from facilities, children in need of medical attention, and children being arrested for crimes that they allegedly committed while at the facilities. In one case, a child ran away from the same facility three times within a 45-day period. In two other instances, two children ran away from their group homes and were still missing at the time of our review. We found no indication that placement agencies had reported any of these incidents to the department.

While placement agencies do not always report such incidents to the department, the facilities also do not always report incidents that jeopardize the health and safety of children. During our review of case files at six facilities, we identified 26 incidents that the facilities should have reported to the department. However, the appropriate department district offices had a record of only 4 (15 percent) of the 26 incidents. All 4 incidents occurred at the same facility.

Incidents that we identified at the facilities are similar to incidents we identified at the placement agencies. In one case, a child was arrested for felony sexual battery against another child. In another case, a child physically assaulted another child. In other incidents, children required medical attention for injuries, and children were arrested for crimes that they allegedly committed while placed at the facilities. Again, the department had not received from the facilities or placement agencies a report of any of these incidents.

Three placement agencies told us that they do not report all incidents to the department because the department's lack of sufficient staff does not permit it to act upon the information. One supervisor at a placement agency stated that the placement agency does not report to the department incidents that occur at facilities because the local district office has ignored license violations at group homes in the past. Further, placement agencies that responded to our survey said that they may report only the most serious incidents to the department and attempt to resolve minor problems directly with the facilities.

Because placement agencies do not always report incidents to the department, the department's monitoring efforts are hindered. The department is not aware of all incidents that occur at facilities and, therefore, cannot observe trends in facility problems. Although placement agencies may resolve problems for individual children, underlying problems at a facility such as inadequate supervision of

children may go unnoticed. For example, although a facility may experience repeated incidents of sexual activity between children, the individual children may be handled separately by different placement agencies. The placement agency representing a child involved in sexual activity may remove its child, but removing one child does not identify and solve the problem at the facility that allows sexual activity among children at the facility to continue.

Moreover, unless placement agencies report incidents to the department, placement agencies responsible for other children living in the facility or that may later place children in the facility have no way of knowing that the incidents occur. The chief of the department's Central Operations Branch told us, for example, that a number of children repeatedly running away from a facility may indicate that the children are not being placed at a facility appropriate for their needs; it may also indicate other problems such as inadequate supervision at the facility. Without information about such incidents, however, the department cannot investigate and determine if a continuing problem does exist.

Because the department has licensing authority over residential facilities for children, the department needs full knowledge of all problems that occur at a particular facility in order to eliminate the problems. Unsafe facilities that keep their licenses will continue to have children placed in them as long as the department lacks information about the unsafe conditions.

The Department Does Not Provide Important Information to Placement Agencies

While placement agencies and facilities do not always report incidents to the department, the department does not always provide placement agencies with important information on its investigations of incidents at facilities. In addition, the department does not always provide to placement agencies background information on facilities and on programs offered by the facilities. As a result, placement agencies may place children in facilities that are unsafe or unsuitable for the children's needs.

Failure To Respond to Placement Agencies That Report Problems in Facilities

State law does not require the department to share its investigation reports with placement agencies. For example, the Health and Safety Code permits but does not require the department to inform placement agencies of substantiated complaints against facilities. Furthermore, department policy requires its district offices to notify placement agencies of substantiated complaints against facilities only if the placement agencies request notification. Otherwise, department policy requires the district offices to notify placement agencies only of administrative actions such as the denial of renewal of a facility's license or the temporary suspension or revocation of a facility's license.

In addition, the department does not always provide feedback to placement agencies that report problems at residential facilities. In our survey, 33 percent of the placement agencies that responded and that had reported problems to the department said they received no information from the department on the resolution of these problems. In one instance, the department cautioned a placement agency against removing a child placed at a facility pending the department's investigation of a complaint about a drowning incident at that facility. Although the placement agency requested a copy of the department's investigation report, it never received the copy. The department substantiated the complaint regarding the drowning incident and did not renew the facility's license, but the department's failure to provide the information that the placement agency requested resulted in the placement agency's keeping a child in a facility that may have been unsafe.

The example above shows that the department does not always notify placement agencies of substantiated complaints even when placement agencies request this information. In addition, placement agencies that do not request notification may never receive any information on substantiated complaints. The chief of the department's Central Operations Branch told us that the department has no system for sharing investigation reports with placement agencies that do not request the reports. Consequently, placement agencies that have children in facilities against which complaints have been substantiated

do not receive the reports.* Without knowing of substantiated complaints, placement agencies may be placing children in facilities that are unsafe.

Failure To Provide Background Information on Facilities

In response to our questionnaire, 43 percent of the placement agencies responding indicated that the department does not share information regarding a particular facility's history of problems. In one case, a placement agency placed a child in a facility while the facility was on probation because the facility operator had administered corporal punishment to several children. A facility on probation must comply with the department's licensing requirements and with any specific probationary conditions; otherwise, the department will automatically revoke the facility's license. According to a supervisor at the placement agency, the department did not inform the placement agency of the facility's probationary status even though the agency had placed another child in the facility several months earlier. Only when the child most recently placed in the facility also alleged that he was physically abused by the facility operator did the placement agency learn from the department about the facility's history of problems.

*Effective January 1, 1985, Chapter 1409, Statutes of 1984, requires the department to notify placement agencies representing children at the facility of the nature of substantiated complaints against the facility.

Furthermore, the department does not provide to placement agencies information about programs at facilities. The regulations require applicants for a facility license to provide to the department a "plan of operation," a written document that describes the methods and goals of the facility's program. Furthermore, a facility, once licensed, must operate in accordance with its program and must report to the department any program changes that affect services to its clients. Any such changes, which are subject to the department's approval, must be reported to the department within ten working days. Sixty-two percent of the placement agencies responding to our questionnaire indicated that the department does not provide information it should have on file on programs offered by particular facilities. Without this information, placement agencies could place children in facilities that do not offer programs most suited to the children's needs. One placement agency, for example, cited instances in which sex offenders that it had placed in facilities later molested other children. Although the placement agency did not consider the placement of the sex offenders in the facilities as most appropriate, the agency was unable to locate facilities that offered programs to treat the sex offenders' problems. The placement agency later inadvertently discovered that a facility with a program for sex offenders operated within its own county.

Because the department is responsible for monitoring the State's residential facilities for children, the department represents the best possible central source of information on facilities'

histories and programs offered by facilities. However, when the department does not or cannot provide to placement agencies background information or information on programs of facilities, the agencies must rely on alternative information sources such as other placement agencies. Discussions among placement agencies, however, represent an informal and incomplete source of information. For example, placement agencies in southern California routinely meet quarterly and informally share information on residential facilities. In our survey of six placement agency supervisors, however, two of the supervisors indicated that this system of information sharing provides a limited view of facilities; the supervisors are reluctant to provide candid assessments of problem facilities at the meetings for fear that these facilities will sue for libel.

State law requires the department to maintain the results of each licensing inspection, evaluation, or consultation of a facility on file and open to public inspection in the county in which the facility is located. According to the chief of the department's Central Operations Branch, a facility's public file represents the only source of background information on the facility available to placement agencies. A facility's public file, however, does not contain a complete history of the facility's problems. For example, the public file does not contain reports by the facility of incidents that jeopardized the health and safety of children placed in that facility. In addition, the public file does not contain information on special programs offered by facilities.

The amount of information available to placement agencies should increase when the department implements the provisions of Chapters 1524 and 821, Statutes of 1984. Chapter 1524 requires the department to establish an automated license information system on licensees and former licensees of licensed community care facilities. The system will maintain a record of any information that may be pertinent to licensure. The department director is allowed to determine what information is pertinent.

Chapter 821 requires the department to provide quarterly to the chief probation officer of each county and each city a roster of all community care facilities licensed as small family or group homes. In addition, the department must provide this roster quarterly to each county and each city that requests it. Furthermore, the department is required to notify in writing the local director of social services and the probation officer of the county in which a community care facility is located within ten days after the facility's license or special permit expires or is suspended, revoked, temporarily suspended, forfeited, or canceled. Chapter 821 does not require the department to provide any information about facilities that is not available on the department's automated information system. Therefore, it is important that the department, in implementing the information system, include information necessary for its monitoring responsibilities. In addition, the automated system should include information that will assist placement agencies in making decisions about the appropriate placement of children.

Although these new laws require the department to improve its licensing information system and to provide to placement agencies information on the status of facilities' licensure, the laws do not specifically require the department to maintain and report other information such as a history of problems at facilities or programs offered by facilities. This information is also useful to placement agencies. Finally, Chapter 1524 does not specify the purpose or use of the information to be maintained by the department's new automated license information system.

We believe the department should design this system to include information that will assist placement agencies in making decisions on the appropriate placement of children and that will help the department schedule timely annual inspections and follow-up visits, monitor criminal record clearances, and process required exemptions. The system could also include a complete history of facilities; such a history would permit the department to readily identify facilities that repeatedly violate regulations.

III

THE SYSTEM FOR INVESTIGATING THE BACKGROUND OF PERSONNEL DOES NOT PREVENT PERSONS WHO HAVE PRIOR CRIMINAL CONVICTIONS FROM WORKING IN CHILDREN'S RESIDENTIAL FACILITIES

The State's system for screening employees of residential facilities for children does not prevent persons who have prior criminal convictions from working in children's facilities. Consequently, children in residential facilities are sometimes exposed to personnel who have been convicted of criminal activity, including use and possession of drugs, sex crimes, and murder. Files in the Department of Social Services lack evidence showing that all facilities submit the required fingerprints of facility personnel; the files also show that other facilities do not submit the fingerprints within the period specified by law. In addition, the department does not require facilities to provide current personnel reports, and it has no routine procedures other than its annual inspection to identify facilities that fail to submit fingerprints or current personnel reports. Moreover, when the Department of Justice does not promptly provide information regarding the background of facility personnel, three of the four district offices that we reviewed have no procedures to determine the reason for delays. Finally, the department has not always processed exemptions that allow persons who have been convicted of crimes to work in facilities. The department has identified some of these deficiencies in a department study. Even if these weaknesses were corrected, however, under the current laws and regulations, persons who

have prior criminal convictions would still be able to work in the facilities for eight weeks or more before the department receives information on their backgrounds.

The Department's "Criminal Record Clearance" System Does Not Identify and Exempt All Personnel Who Have Prior Criminal Convictions

The department's files lack evidence showing that all residential facilities for children have submitted fingerprints of employees. In addition, the files show that some facilities do not submit fingerprints promptly, and some facilities have not submitted current personnel records. Finally, the department has delayed processing fingerprints and has failed to process exemptions. A department study has identified some of these problems.

Lack of Evidence Showing That Facilities Submit All Required Fingerprints

The California Health and Safety Code requires the department, before licensing a community care facility, to determine that the applicant for the license and other facility staff have not been convicted of crimes other than minor traffic violations. To make this determination, the department obtains the applicant's fingerprints, fingerprints of all staff who will have frequent and routine contact with the children, and fingerprints of any person other than a child who will be residing in the facility. If the applicant is a

corporation, the code requires fingerprints of the chief executive officer or person acting in that capacity. Facilities that are already licensed must submit fingerprints of all new employees no later than 20 days after the employees are hired. The department sends the fingerprints to the Department of Justice to obtain information on prior convictions. The department refers to this process as a "criminal record clearance."

Our review of the files of 130 facilities in four district offices revealed that the department lacks evidence that all facilities submit fingerprints required in the criminal record clearance. The department did not have evidence that it had received fingerprints for a least one current employee in 32 of the 130 facilities in our sample. The file of one group home in the Riverside/San Bernardino district contained no evidence that the facility submitted the fingerprints on any new staff from December 1982 through 1984 even though the facility hired new staff in 1984. The file of another group home in the South Los Angeles district contained no evidence that the home had submitted fingerprints for 16 employees who were listed on its current personnel record. The department did not cite either of these facilities for failing to comply with the regulations.

While files for some facilities do not show that the facilities submitted fingerprints at all, files on other facilities that did submit fingerprints show that the facilities did not submit fingerprints promptly. For instance, a facility in San Bernardino

County delayed submitting employees' fingerprints to the department for as long as six months. The California Health and Safety Code requires facilities to submit fingerprints within 20 days after employees are hired. Delay in submitting fingerprints increases the period during which the department has no information on the staff and, therefore, cannot identify persons who should not be permitted to work with children in the facilities.

The department's system for investigating employees' backgrounds is especially ineffective when facilities fail to submit the fingerprints as required because the department has no routine procedures, except for its annual inspection, for monitoring facilities' compliance with fingerprint requirements. Although during its annual inspection, the department verifies that all facility employees have been fingerprinted and cleared for criminal convictions, the system is weakened further when, as reported earlier in this report, the department does not make the annual inspection.

Failure of the Department To Obtain Current Personnel Records

As of January 1, 1984, group homes and small family homes must submit to the department complete personnel reports before obtaining licenses and report any changes in personnel after obtaining the licenses. Before January 1, 1984, this requirement applied only to group homes. A personnel report is a form on which the licensee lists the facility's employees, describes their duties, and indicates the

date the employees were hired. A current personnel report permits the department to compare the facility's list of the current staff with the list of persons for whom the department has received fingerprints and performed a criminal record clearance.

Our review revealed that the department had not obtained personnel reports for 61 (47 percent) of the 130 facilities in our sample. Files for 44 (60 percent) of 73 small family homes and 17 (32 percent) of 53 group homes did not contain current personnel reports. Furthermore, the managers of the district offices have not insisted that their evaluators obtain current personnel reports. In our review of four district offices, we found that some evaluators did not consistently require licensees to submit current, complete personnel reports at each annual evaluation or to update these reports during the year.

The department's failure to maintain current personnel reports for each facility is a major factor contributing to the lack of criminal record clearances for all employees. Because the department does not enforce the requirement that all of the facilities submit and update personnel reports, the department is unable to effectively monitor the facilities' compliance with the requirements that all persons working in residential facilities for children have criminal record clearances.

Delays in
Processing Fingerprints

Another factor hindering criminal record clearances of facility staff is the delay by the department in processing fingerprints. Although all four district offices submit the fingerprints to the Department of Justice, we found that the North Los Angeles and South Los Angeles district offices both required from one to two weeks to process fingerprints and forward them to the Department of Justice. Moreover, even when fingerprints are submitted promptly, three of the district offices have no procedures to determine the reason for delay if they do not receive a response from the Department of Justice within a reasonable time. The fourth district office follows up with inquiry to the Department of Justice approximately 90 days after initial submission.

Inadequate fingerprints also contribute to delays. In some cases, the fingerprints submitted to the Department of Justice are not clear enough to be identified, and the employees must be fingerprinted again. In one instance, the department and one facility had been trying to get acceptable prints to the Department of Justice for nearly two years. During such delays, personnel continued to work with children without having criminal record clearances.

Following submission of the fingerprints to the Department of Justice, there is further delay in obtaining information back from the Department of Justice. According to the supervisor of the fingerprint

section that serves the two Los Angeles district offices, the Department of Justice requires three to four weeks to respond to the department's request for information on criminal records. However, our review at these offices revealed that the Department of Justice took from four to eight weeks to respond after the department submitted the request for information. In one instance, the South Los Angeles district office had submitted fingerprints to the Department of Justice for six employees in one facility. At the time of our review, six months had elapsed since the prints were submitted, and the Department of Justice still had not provided information about the employees. During this period, the employees continued to work with children.

Failure of the Department To Process Exemptions

State licensing laws and regulations allow the department to exempt persons convicted of certain crimes from the regulations prohibiting them from working in children's facilities. To authorize an exemption, the department must review the circumstances surrounding the offense, the type of crime committed, the length of time since the conviction, and the person's subsequent activities and behavior. The department uses this review to determine if the person has been rehabilitated and may be allowed, therefore, to work in the facility. The department cannot, however, grant an exemption to persons convicted of the following crimes: murder or voluntary manslaughter; mayhem; rape, sodomy or oral copulation by force, violence, duress, menace, or threat of great bodily harm; lewd acts committed against a child under

14 years of age; any felony punishable by death or imprisonment in state prison for life; or any other felony in which the defendant inflicts great bodily injury on any person other than an accomplice.

We found that the department has not always required the facilities to request exemptions for persons convicted of crimes before permitting them to work in facilities. For approximately four years, one group of facilities in Butte County had employed a number of persons who had been convicted of crimes; the department had never approved exemptions for them. At the time of our review, these persons were no longer employed at the facilities.

In a facility in the Riverside/San Bernardino district, a person who attested to having a felony conviction worked for approximately eight months at the facility with the department's knowledge. Only after receipt of information from the Department of Justice indicating that this employee had been convicted of murder did the department advise the facility to suspend the employee until the department reached a decision on an exemption. Although a murder conviction precludes the granting of an exemption, at the time of our review, the department still had not denied the facility's exemption request to allow this person to work in the facility.

An employee of another facility in the North Los Angeles district had been convicted of using drugs. The department did not become aware of his criminal record until the employee had worked at

the facility for approximately one year. The department did not require the facility to request an exemption for this employee before the employee's termination from the facility, approximately 14 months after he was employed.

The Department's Fingerprint Study

During our review, the department was also conducting a study of the system for obtaining fingerprints and records of criminal convictions. As of February 7, 1985, the study was not complete; however, documents provided to us indicate that staff had reviewed the fingerprint system at seven district offices and had identified some of the same deficiencies that we discussed in this report. The major deficiencies that the department identified include the following: a high rate of error (25 percent) in securing fingerprints sufficiently clear so that the Department of Justice can classify and process them; delays in processing fingerprints by the district offices; and failure of district offices to keep track of and follow up on fingerprints submitted to the Department of Justice. The department also identified the problems of limiting the number of times that facilities submit unclassifiable fingerprints and avoiding unnecessary fingerprinting of employees in community care facilities. At present, persons who hold a criminal record clearance and change employment to another facility must submit another set of fingerprints.

Improvements in Procedures and Compliance With Regulations Will Not Prevent Persons Who Have Prior Criminal Convictions From Working in Children's Residential Facilities

Even if the facilities submit all fingerprints as required by licensing laws and regulations and even if the Department of Social Services and the Department of Justice process the fingerprints promptly, the system still will not prevent persons who have prior criminal convictions, but who have not yet been exempted, from working in children's facilities.

Section 1522(c) of the Health and Safety Code allows a licensee 20 days in which to submit fingerprints of employees to the department. The 20-day period begins with the person's initial date of employment, residence, or presence in the facility. After receiving the fingerprints, the department takes about one week to "log in" the fingerprints, set up a file, and submit the fingerprints to the Department of Justice. The Department of Justice requires from four to eight weeks to respond to the department's request for information.

Table 2 on the following page shows the amount of time that can elapse from the time a person begins working at a residential facility for children until the department receives information on the employee's background.

TABLE 2

TIME ALLOWED OR REQUIRED FOR PROCEDURES IN OBTAINING CRIMINAL RECORD CLEARANCES FOR EMPLOYEES IN CHILDREN'S FACILITIES

Procedure	Time
Facility submits fingerprints to the Department of Social Services	20 days
Department of Social Services processes fingerprints and submits them to the Department of Justice	7 days
Department of Justice responds	28 days
Total	55 days

As the table illustrates, under the current law and regulations, a new employee can work in a facility for approximately eight weeks before the department can obtain any information from the Department of Justice on the employee's background and can take steps to process an exemption or remove from a facility a person who has prior criminal convictions.

In a North Los Angeles district facility an employee was a "registered sex offender" because he had been previously convicted of offenses that included annoying or molesting children and assault with intent to commit rape.* The employee worked in the facility for

*Section 290 of the Penal Code requires persons convicted of rape or attempted rape to register that information with the police or sheriff in the area of his/her residence.

approximately two months before resigning. However, the department did not receive the individual's criminal record until approximately three months after the employee was employed by the facility. If the employee had not resigned, the employee could have worked in the facility for the entire three months before the department had any information upon which to take action. Moreover, because of the time required to obtain a criminal record clearance, the person could have continued to work indefinitely at residential facilities for children simply by periodically changing employment to another facility. The department would not be able to take action against this person's employment unless the person happened to be employed by a facility when the department received the criminal record.

Before 1983, state law required persons to be fingerprinted and "cleared" before being permitted to operate community care facilities. This provision of the law was changed in 1983 to include employees. However, the law gives facilities 20 days to evaluate any employee's probability of success at the facility before having to submit the fingerprints and pay the cost of processing and checking the employee's criminal record.

Most of the State's residential facilities are not charged for the cost of checking a person's criminal record. Our review indicated that 85 percent of residential facilities for children are exempt from the processing costs. For facilities that provide nonmedical board, room, and care for six or fewer children, Section 1522 of the Health

and Safety Code prohibits the Department of Justice or the Department of Social Services from charging for processing the fingerprints of the applicants for a license or the fingerprints of employees. This exemption includes all small family homes and group homes licensed for six or fewer children. Therefore, since our review indicated that 85 percent of the facilities for children are exempt from fees for obtaining criminal record clearances for their employees, we see no reason why these facilities should be allowed to wait 20 days before submitting the fingerprints to the department.

IV

CONCLUSION AND RECOMMENDATIONS

The Department of Social Services has failed to regulate effectively residential facilities for children. In the four district offices that we visited, the department failed to take action against some facilities that repeatedly violated licensing laws and regulations. The department has not always conducted the required annual inspections. Furthermore, the department has not always followed up to ensure that facilities corrected deficiencies. In addition, some of the department's inspections were not thorough and well-documented. Moreover, the department and placement agencies are not sharing information with each other to enhance the effectiveness of their respective responsibilities to ensure that children are placed in facilities that provide safe and healthy environments. Finally, the system for investigating the background of persons working with the children is not effective in preventing persons who have prior criminal convictions from working in the facilities.

Recommendations

To improve its regulation of residential facilities for children, the Department of Social Services should take the following actions:

- Improve the supervision at the district offices to ensure that evaluators conduct all the required annual inspections and make follow-up visits to ensure that facilities correct all deficiencies. Supervisors should ensure that evaluators conduct thorough, well-documented evaluations and should periodically review the evaluators' work.

- Require evaluators to verify information they receive from placement agencies and facility administrators and direct the evaluators to compile a "facility profile" so the department can identify facilities that present more problems than others. The department can then focus more of its limited resources on the facilities that have frequent problems.

- Describe action to be taken against a facility that is repeatedly cited for serious deficiencies. The department should place facilities with serious problems on a "case management schedule" and conduct quarterly evaluations. If after one year, the facilities do not improve operations, the department should initiate action to deny renewal of the facility's license or revoke its license.

- Require district offices to improve their processing and follow up of criminal record clearances. District offices should obtain current personnel records, identify facilities that do not submit fingerprints, determine the status of fingerprint clearances in process, and, when the Department of Justice does not provide information promptly, follow up and identify the cause for the delay.

- Develop and maintain in its information system required by Chapter 1524, Statutes of 1984, a history of employees of residential facilities for children, in addition to the currently required history of licensees and former licensees. The history should document current information on the employees' fingerprint clearances and any administrative actions that the department has upheld against the employees. The history could also include other information on employees, such as first aid training, tuberculosis test results, and other medical information. This information would reduce the number of criminal record clearances the department would need to process, and it would also allow the department to quickly screen facility employees who move from one facility to another.

To improve coordination of monitoring by the department and placement agencies, the Legislature should take the following action:

- Enact legislation requiring the department and placement agencies to share information. The legislation should require the department to develop procedures that enable placement workers to report violations of regulations and should require placement workers to report violations on a standard checklist. The legislation should also require placement workers to report to the department on a regular basis any violations of the regulations that they observe in facilities they visit. Further, the legislation should require placement agencies to report to the department any information the placement agencies have regarding incidents that could jeopardize the health and safety of children in residential facilities.

To ensure that placement agencies place children only in facilities that are safe and appropriate for children's specific needs, the Legislature should enact legislation requiring the department to incorporate into its information system required by Chapter 1524, Statutes of 1984, a complete history of problems at facilities, and the information the department should have about programs offered by the facilities. The department should be directed to share this information with placement agencies.

Finally, to improve the effectiveness of the system for investigating the backgrounds of persons working in residential care facilities for children, the Legislature should enact legislation requiring all small family homes and group homes to submit to the department the fingerprints of new staff at the time the employees commence work at the facility.

We conducted this review under the authority vested in the Auditor General by Section 10500 et seq. of the California Government Code and according to generally accepted governmental auditing standards. We limited our review to those areas specified in the audit scope section of this report.

Respectfully submitted,

THOMAS W. HAYES
for Auditor General

Date: April 29, 1985

Staff: William S. Aldrich, Audit Manager
Georgene L. Bailey
Michael R. Tritz
H. Thomas Blanchette
Frank A. Luera

State of California **Health and Welfare Agency**

Memorandum

To : Thomas W. Hayes, Auditor General
660 J Street, Suite 300
Sacramento, CA 95814

Date : April 24, 1985

Subject:

From : **Department of Social Services**, 744 P Street, Sacramento, CA 95814

We appreciate the opportunity to review your draft report on State Licensed Residential Facilities for Children. My staff has discussed the report with your audit staff and several changes were made which better reflect our licensing authority and responsibilities as they are discussed throughout the report. Therefore, I will restrict my comments to the conclusions and recommendations as shown on pages 65 - 69.

CONCLUSION AND RECOMMENDATIONS

The Department of Social Services has failed to regulate effectively residential facilities for children. In the four district offices that we visited, the department failed to take action against some facilities that repeatedly violated licensing laws and regulations. The department has not always conducted the required annual inspections. Furthermore, the department has not always followed up to ensure that facilities corrected deficiencies. In addition, some of the department's inspections were not complete, thorough, and well-documented. Moreover, the department and placement agencies are not sharing information with each other to enhance the effectiveness of their respective responsibilities to ensure that children are placed in facilities that provide safe and healthy environments. Finally, the system for investigating the background of persons working with the children is not effective in preventing persons who have prior criminal convictions from working in the facilities.

Response

The statement that the Department has failed to regulate effectively residential facilities for children implies that all facilities are problem facilities - this is not true.(1)* What is true is that some facilities have recurring problems, some facilities require more frequent oversight, and some facilities require action against their license. It is important to state that our Department's philosophy is not to see how many homes we can close down, but rather to bring facilities into compliance with licensing requirements so they can provide quality care for community care clients. The Department has a number of enforcement tools starting with evaluation visits that result in agreements to make changes or corrections to bring facilities into compliance, moving next to the levying of civil penalties, and ending with administrative action against the license. At times the report implies that unless we take administrative action against the license we are not doing anything to improve conditions in the facility. That is only one tool and the last one that we use.(2)

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* The Auditor General's comments on specific points contained in the agency's response begin on page 77.

Recommendation

To improve its regulation of residential facilities for children, the Department of Social Services should take the following actions:

- *Improve the supervision at the district offices to ensure that evaluators conduct all the required annual inspections and make follow-up visits to ensure that facilities correct all deficiencies. Supervisors should ensure the evaluators conduct thorough, well-documented evaluations and should periodically review the evaluators' work.*

Response

We concur with the recommendation. At some time periods covered by this review, the offices were understaffed because of attrition, turnover, and temporary personnel restrictions. This resulted in the program having to set priorities and in some cases not conducting all the required annual inspections. However, in regard to this recommendation, most important is the Department's plan to develop a management information system (MIS) which will enable the managers to keep track of the problems at facilities, the visits required for each facility, and to schedule the visits appropriately. Funding for the MIS is proposed in the 1985/86 budget and the feasibility study is pending approval at the Department of Finance.

Recommendation

- *Require evaluators to verify information they receive from placement agencies and facility administrators and direct the evaluators to compile a "facility profile" so the department can identify facilities that present more problems than others. The department can then focus more of its limited resources on the facilities that have frequent problems.*

Response

To a degree, resources are already focused on problem facilities through follow-up visits on complaints. This results in problem facilities having more visits than the average facility since we still perform the required visits in addition to complaint visits. Additionally, the management information system will highlight facilities that have recurring problems so that we can make a concerted effort to focus our visits on the problems.

Recommendation

- *Describe action to be taken against a facility that is repeatedly cited for serious deficiencies. The department should place facilities with serious problems on a "case management schedule" and conduct quarterly evaluations. If after one year, the facilities do not improve operations, the department should initiate action to deny renewal of the facility's license or revoke its license.*

Response

More frequent evaluations are costly and would not necessarily be productive.③ Legislation is being considered this session which would increase the fines levied by the Department for repeat violators, and would enable us to levy them immediately when the same problem recurs. This is a bigger stick than we now have and should make it easier to obtain compliance. It should be pointed out that the term serious deficiency is a regulatory definition used for the purpose of assessing fines. It should not be viewed as the equivalent to life threatening situations which require administrative action against the license.④

Recommendation

- *Require district offices to improve their processing and follow up of criminal record clearances. The improvements should require district offices to obtain current personnel records, to identify facilities that do not submit fingerprints, to determine the status of fingerprint clearances in process, and, when the Department of Justice does not provide information promptly, to follow up and identify the cause for delay.*

Response

We generally agree with this recommendation and are initiating administrative changes to improve our processing of fingerprints. The changes we are initiating involve initial review of fingerprint cards to screen out unprocessable cards and the institution of better, standardized control systems in each of the offices to track the status of fingerprint clearances.

Recommendation

- *Develop and maintain in its information system required by Chapter 1524, Statutes of 1984, a history of employees of residential facilities for children, in addition to the currently required history of licensees and former licensees. The history should document current information on the employees' fingerprint clearances and any administrative actions that the department has upheld against the employees. The history could also include other information on employees, such as first aid training, tuberculosis test results, and other medical information. This information would reduce the number of criminal record clearances the department would need to process, and it would also allow the department to quickly screen facility employees who move from one facility to another.*

Response

We agree with this recommendation and our plans for the new information system provide that most of this type of employee information will be in the system. It will primarily be based on our fingerprint clearance program.

Recommendation

To improve coordination of monitoring by the department and placement agencies, the Legislature should take the following action:

- *Enact legislation requiring the department and placement agencies to share information. The legislation should require the department to develop procedures that enable placement workers to report violations of regulations and should require placement workers to report violations on a standard checklist. The legislation should also require placement workers to report to the department on a regular basis any violations of the regulations that they observe in facilities they visit. Further, the legislation should require placement agencies to report to the department any information the placement agency has regarding incidents that could jeopardize the health and safety of children in residential facilities.*

Response

Legislation to accomplish this is pending and could improve the information network on community care facilities. We support the concept of sharing information between licensing and placement agencies. While this typically happens now, it is appropriate to formalize it through legislation.(5)

Recommendation

To ensure that placement agencies place children only in facilities that are safe and appropriate for children's specific needs, the Legislature should take the following action:

- *Enact legislation requiring the department to incorporate into its information system required by Chapter 1524, Statutes of 1984, a complete history of problems at facilities. The information should also include information that the department should have on programs offered by the facilities. The department should be directed to share this information with placement agencies.*

Response

We support this concept and will be developing our information system to include complaints or deficiencies at facilities. As far as the second aspect of the recommendation, we don't have any problem as long as it is recognized that we have limited program information required by our licensing regulations, since we license facilities, not programs.(6)

Recommendation

To improve the effectiveness of the system for investigating the backgrounds of persons working in residential care facilities for children, the Legislature should take the following action:

- *Enact legislation requiring all small family homes and group homes to submit to the department the fingerprints of new staff at the time the employees commence work at the facility.*

Response

If the Legislature enacted this change, it would not require a change in our efforts. Instead, it would place a requirement on facility operators to submit fingerprint cards immediately, instead of waiting twenty days.

I appreciate the opportunity to respond to your audit, and appreciate your assistance in providing program oversight.

Linda S. McMahon

LINDA S. McMAHON
Director

AUDITOR GENERAL'S COMMENTS ON THE HEALTH AND WELFARE AGENCY'S RESPONSE

The comments that follow address specific points made by the department. The numbers correspond to numbers we have placed in the department's response.

(1) We do not indicate that all facilities are problem facilities; in fact, we clearly state that the department has failed to take action against some facilities that repeatedly violate licensing laws and regulations.

(2) We recognize that administrative action to deny the renewal of a license or to temporarily suspend or revoke a license is a severe penalty. We point out on pages 13 through 22 of the report, however, that since some facilities repeatedly violate the same regulations, the tools that the department currently uses do not appear to produce any lasting improvements.

(3) As we point out in note #2 above, the department needs effective regulatory tools that fall between citing deficiencies and taking administrative action. More frequent inspections of problem facilities will provide the department with the opportunity to better assist those facilities that will correct problems. In addition, the department will be able to identify those facilities against which administrative action is warranted and to gather sufficient evidence to support such action.

(4) The department responds that "the term serious deficiency is. . .for the purpose of assessing fines. . .[and] should not be viewed as the equivalent to life threatening situations . . ." We must point out, however, that the department's own regulations define a serious deficiency as "a deficiency that presents an immediate or substantial threat to the physical health, mental health, or safety of the clients of a community care facility." Moreover, the department's written policy clearly states that lack of a criminal record clearance and a fire clearance "are two requirements that are essential to ensure the provision of adequate and safe care to clients." [emphasis added]

(5) Contrary to the department's assertion, we found that the department and placement agencies do not typically share information. As discussed on pages 46 and 47 of our report, 43 percent of the placement agencies responding to our questionnaire reported that the department does not share information regarding a facility's history of problems, and 62 percent said the department does not provide to placement agencies information about programs at the facilities. Furthermore, the department's files contained information on only 24 percent of the incidents that jeopardized the health and safety of children for which the placement agencies had a record. (See page 40 of our report.)

(6) We must emphasize the department's regulations require facilities to submit their programs to the department to obtain a license and must report to the department all changes within ten working days of the change. (See page 47 of our report.)

SYNOPSIS OF THE 1980 AUDITOR GENERAL REPORT ON RESIDENTIAL FACILITIES FOR CHILDREN

Report P-003.1 -- Improvements Warranted in Licensing of Residential Care Facilities for Children

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

In addition to these problems with the administration of residential care facilities, the department has not performed criminal record reviews for more than half of the facility staff requiring such reviews. Further, certain persons who have felony and misdemeanor convictions have been allowed to work in facilities licensed by the State and the county even though they have not been granted exemptions to do so. Because of this inadequate review of personnel, children are exposed to unnecessary risks that may endanger their physical and mental health.

Finally, California does not have an information system that enables placement agencies and concerned citizens to select a community care facility on the basis of quality of care. Although the Health and Safety Code requires such a system, the department has not implemented this requirement because of difficulties in constructing a system for rating various facilities. Although we agree that a rating system may be difficult to implement, an information system could provide placement agencies and other concerned parties with inspection reports and complaint data.

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

should comply with existing laws and regulations by conducting criminal record reviews for all personnel who provide service to or who are employed by any residential facility.

Additionally, the department should grant exemptions for facility personnel determined to be suitable to care for children or ensure that those facility personnel who are inappropriately qualified are prohibited from working in residential facilities. Finally, to provide adequate information to placement agencies and concerned citizens, the Legislature should consider requiring the department to submit plans to implement a comprehensive information system.

AREAS IN WHICH PLACEMENT WORKERS CAN OBSERVE VIOLATIONS THAT CAN JEOPARDIZE CHILDREN'S HEALTH AND SAFETY

Listed below are 19 kinds of violations that could jeopardize children's health, safety, and welfare. As part of our questionnaire, we asked placement workers if they could provide information on these violations.

1. Death, injury, unusual incidents reported as required
2. Minor's cash resources, personal property/valuables safeguarded
3. Sufficient, competent personnel. Day and night staff/minor ratios as required (group home)
4. Consultation from a professional as required (group home)
5. Licensee regularly present in the home (small family home)
6. Adequate substitute when licensee is absent (small family home)
7. Current admission agreements on file for each minor
8. Emergency medical consent forms on file for each minor
9. Evidence of health/dental exams, immunizations for each minor.
10. Intake study, appraisal, needs and services plan for each minor, updating as required
11. Minor's records complete, updated, and confidential
12. Services, activities, and equipment provided to meet minor's needs and goals
13. Personal rights ensured; no physical, mental, verbal abuse
14. Constructive and fair means of discipline used
15. No behavioral restraints except as approved by licensing agency
16. Medications stored and locked appropriately
17. Facility clean, safe, sanitary, and in good repair
18. Suitable education provided for minors
19. Minors safe from hazards

cc: Members of the Legislature
Office of the Governor
Office of the Lieutenant Governor
State Controller
Legislative Analyst
Assembly Office of Research
Senate Office of Research
Assembly Majority/Minority Consultants
Senate Majority/Minority Consultants
Capitol Press Corps