Telephone:
(916) 445-0255

STATE OF CALIFORNIA
Office of the Auditor General
660 J STREET, SUITE 300
SACRAMENTO, CA 95814

Thomas W. Hayes
Auditor General

June 27, 1988

P-578.2

Honorable Bruce Bronzan, Chairman
Members, Joint Legislative
Audit Committee
State Capitol, Room 448
Sacramento, California 95814

Dear Mr. Chairman and Members:

The Department of Social Services (department) complied with state law and department procedures when it investigated allegations of sexual abuse in Zanadu Group Home (Zanadu) in Madera County and Mountain Oaks Transitions Group Home, Inc., (Mountain Oaks) in Shasta County in 1986. However, after its investigations, the department could have shortened, by approximately 6 to 26 weeks, the nine months that it took to begin revoking the Zanadu license. In addition, it could have shortened, by approximately 5 weeks, the four months that it took to begin revoking the Mountain Oaks license. Even if the department had begun its license revocation process sooner against the licensees of the two group homes, the department's procedures do not allow an adequate balance between protecting the health and safety of children placed in a group home and preserving the licensee's business during an investigation. For example, placement agencies permanently removed their clients from Mountain Oaks after the allegations had been made. Having no clients, the licensees of Mountain Oaks sold their home seven weeks after the allegations although the department had not even proposed to revoke their license. Conversely, although placement agencies also removed their clients from the Zanadu home at the time of the allegations, the home was able to maintain its business with other clients. However, if the allegations of abuse in a group home are true, potential danger can exist for residents if the accused remains on the premises in that home. As of June 7, 1988, the two revocation cases were still pending.

Background

In 1973, the California Community Care Facilities Act (Section 1500, et seq. of the Health and Safety Code) was enacted to ensure that all persons needing community care facilities, such as children who are wards of the court, are served by facilities that meet established health and safety standards.

As of December 31, 1987, the Department of Social Services (department) reported that California has approximately 70,000 licensed community care facilities. Community care facilities include about 25,000 residential care facilities with a total capacity of approximately 139,000 clients. The department directly licenses and regulates about 10,000 residential care facilities, such as group homes for children, through its 15 district offices. County welfare departments license the remaining 15,000 residential care facilities, such as foster homes, through contracts with the State. The department issues a license to an applicant for a specific facility. The facility itself as well as the program and administration must meet the requirements of state law and regulations.

When allegations of sexual abuse of children occur, Section 11165, et seq. of the Penal Code (the State's law for reporting child abuse) requires that persons such as school personnel and social workers report the suspected abuse to a child protective agency immediately or as soon as practically possible. A child protective agency--police, welfare, probation, or sheriff's departments--investigates an allegation of suspected child abuse.

Agencies such as county welfare and probation departments place clients in licensed residential facilities and are responsible for protecting the health and safety of these clients. Child protective agencies generally are responsible for determining whether to remove children from residential facilities when circumstances such as sexual abuse in a group home are alleged to have occurred.

Department procedures instruct staff to communicate and to coordinate activities with placement agency staff to ensure the protection of the clients' health and safety. This communication may include meetings or telephone conversations to alert the placement agencies to possible problems with a facility before the department takes any action. If the department determines, during its routine evaluations or investigations of complaints, that unsafe or unhealthy conditions exist, it cites the licensee for specific violations of the law. If

problems in the facility are serious enough, the department can take administrative action by issuing a temporary suspension order to close the facility and by revoking the facility's license. Whenever the department suspends or revokes a license, Section 1555 of the Health and Safety Code requires the department to notify the local county director of social services and the probation officer of the county in which the facility is located.

When the department begins its legal procedures to revoke a license, it sends a formal accusation notifying the licensee of the grounds upon which the department seeks to revoke the facility's license. The licensee may appeal the proposed revocation within 15 days by requesting an administrative hearing. Section 1550 of the Health and Safety Code requires that temporary suspension orders be brought to a hearing before an administrative law judge within 30 days of the request by the licensee. If the hearing is not for a temporary suspension order, the department does not have to act within a defined time. Although Section 1551 of the Health and Safety Code states that the department must begin and process license revocations in a timely and expeditious manner, neither the law nor department regulations provide any precise time limits.

In 1986, allegations of sexual abuse were reported at two unrelated group homes for teenage girls, Zanadu Group Home in Madera County and Mountain Oaks Transitions Group Home, Inc., in Shasta County. Two former residents of Zanadu alleged to the Kern County Sheriff's Department that sexual abuse by one of the licensees occurred in 1981, 1982, and 1983. At Mountain Oaks, a resident alleged to a counselor at school that she was sexually abused by one of the licensees during several months before her allegation. Attachment 1 provides a chronology of the allegations and investigations for Zanadu and Mountain Oaks.

Attachment 2 includes a description of the investigations of these sexual abuse allegations at both homes. Hearings before an administrative law judge are complete in both cases, and the proposed decisions were pending as of June 7, 1988.

Scope and Methodology

We reviewed the department's investigations of Zanadu and Mountain Oaks for the periods between the allegations to the department of the sexual abuse and the department's formal actions to revoke the licenses. In

addition to reviewing the investigations, we evaluated the department's licensing of the two group homes for compliance with state law and regulations.

To determine whether the department properly licensed the facilities and investigated the complaints of sexual abuse against the two group homes, we examined the statutory and regulatory requirements for issuing and revoking licenses. We evaluated legal case files at department headquarters and public and confidential case files at the department's district offices for community care licensing in Fresno and Chico. We also reviewed reports by law enforcement agencies and placement agencies. Further, we interviewed department licensing staff, department attorneys, law enforcement staff, and licensees of the two group homes.

In addition, to further determine the effects of the department's procedures both on children who are residents of group homes and on residential care providers, we reviewed state law and regulations for reporting child abuse in group homes, and we interviewed representatives of a group home association as well as placement agency staff.

The Department of Social Services Could Have Shortened the License Revocation Process

In the cases of both Zanadu and Mountain Oaks, the department complied with state law and the administrative code when it investigated allegations of sexual abuse against licensees of the homes. The department also filed proposed revocations of the licenses for both homes. However, although state law and regulations do not define precise time limits within which the department must begin and process license revocations, the department could have shortened the time between completing its field investigations and the formal notification of its proposed administrative action. In the Zanadu case, the department could have shortened, by 6 to 26 weeks, the nine months that it took to begin revoking Zanadu's license after it had completed its investigation. Also, in the Mountain Oaks case, the department could have shortened, by 5 weeks, the four months that it took to begin revoking Mountain Oak's license after completing its investigation.

According to the attorney assigned to the Zanadu case, although he was assigned the case on October 17, 1986, he did not work on the case for six weeks because he was working on other cases. He said that he did

not realize that he needed to contact one of the alleged victims quickly, before she entered military basic training. As a result, although he attempted to contact her in December 1986 to determine if she was willing to testify, he told us that he was not able to talk to her until she called him in April or May 1987 after she had completed basic training. On May 4, 1987, the attorney obtained permission from the military legal staff for her to testify. According to the attorney, during the three months from May through July 1987, he revised the draft accusation to revoke the license for Zanadu while he worked on other cases also involving license revocations and temporary suspension orders.

The department's assistant chief counsel on the Zanadu case indicated that, although nine months is a long time to prepare a license revocation, nine months might be reasonable under some circumstances. However, he also stated that the Zanadu case took longer than it should have and that the department could have proceeded sooner than the July 31, 1987 date of its notice of the proposed license revocation and its decision not to pursue a temporary suspension order for Zanadu. According to the assistant chief counsel, if the attorney had contacted the alleged victim before she entered the military, the department could have sent the notice of the proposed license revocation for Zanadu earlier than July 31, 1987. In our opinion, if the attorney had contacted the alleged victim in October 1986 when he was assigned the case, the department could have prepared the license revocation approximately six weeks sooner. Further, if department staff had then immediately drafted and revised the license revocation document within a period of three months, as it did from May to July 1987, it could have sent the license revocation for Zanadu by February 1987, as much as 26 weeks earlier.

In the Mountain Oaks case, the department's deputy director for legal affairs stated that the four months taken by the department to prepare its case for revoking the Mountain Oaks license was not long for such cases. However, we found that the department could have shortened the time that it took to begin its administrative action. On January 22, 1987, the department requested that an attorney review the case, but it did not assign an attorney until March 3, 1987, five weeks later. The deputy director for legal affairs stated that five weeks was an unusually long time for assigning a case, although it was also very rare. The supervising attorney for the Mountain Oaks case stated that the department did not assign a number to the case at the time of the request, and as a result, the case was not immediately assigned to

an attorney. If the attorney had been assigned sooner, the department could have begun to prepare its administrative action to revoke the license approximately five weeks sooner.

According to the deputy directors for the Community Care Licensing Division and the Legal Affairs Division, it is the department's policy to act as rapidly as possible in administrative action cases because delays can weaken the department's case. However, in the cases of the Mountain Oaks and Zanadu group homes, the department neglected to ensure that its legal division begin working on the cases promptly even though the department's field operations branch suggested possible temporary suspension orders in both cases.

While the department investigates allegations against a group home and its licensee, the license remains valid until the department revokes or suspends the license. For example, even though placement agencies using Zanadu removed their clients at the time of the allegations, at least two other placement agencies later placed clients in Zanadu, and the home also continued to serve private clients. Since a group home under investigation may remain open for business, processing delays could expose residents of the group home to danger if the allegations of abuse are true and the accused remains on the premises of the facility.

More Balance Needed Between the Health and Safety of Residents and the Business of Licensees of Group Homes

Even if the department had taken less time to process the allegations of abuse against licensees, the department's procedures do not allow an adequate balance between protecting the health and safety of children placed in a group home and preserving the licensee's business during an investigation. The Welfare and Institutions Code assigns to placement agencies the responsibility for the welfare of children placed in community care facilities. When allegations of sexual abuse occur, Section 11166 of the Penal Code requires school personnel and certain other persons to report the abuse immediately to a child protective agency. Although placement workers can choose to leave their clients in a group home with a pending license revocation, three of the six agencies that we contacted typically would remove their clients when allegations of sexual abuse occur, until the department resolves its revocation action. In addition, according to the licensees of one home and the placement agencies that we contacted, placement agencies often will not place children as residents in a home whose license the

department is proposing to revoke. Placement workers generally remove clients or choose not to place them to protect them from the potential dangers of alleged abusers. However, the loss of clients under these circumstances can seriously damage a licensee's business, and the abrupt removal of clients can result in emotional trauma for those clients.

In the cases of Zanadu and Mountain Oaks, placement agencies removed their clients from the group homes after the allegations. In February 1987, the original licensees of Mountain Oaks forfeited their license under Section 1524(a) of the Health and Safety Code because they sold their group home business. Although the original license was still valid until the February sale, the home had no clients and therefore no income.

In an attempt to protect the business during the investigation, one licensee of Mountain Oaks obtained a voluntary restraining order to keep the accused licensee off the premises. However, the department does not provide procedures that accused licensees of group homes can implement to assure placement agencies that they are off the premises. Because of the lack of assurance, the Shasta County child protective services agency never allowed the residents to return to Mountain Oaks despite the voluntary restraining order. The manager of the department's district office told us that the department had no authority over the voluntary restraining order and, further, that the licensees remained on the board of directors for the group home's corporation. Therefore, according to the department's district manager and the county's manager for the child protective services agency, these agencies could not be assured that the licensees were off the premises of the group home.

In addition to licensees losing clients and possibly losing their businesses, when placement agencies abruptly remove their clients from group homes, the children can suffer trauma from the transfer. For example, one resident of Zanadu who had lived in the home for three years was upset when the placement agency removed her shortly before her high school graduation. In another example, the therapist of one resident of Mountain Oaks reported that her client experienced emotional trauma from the sudden and permanent removal from the home.

The operator of another licensed group home told us that he had offered to administer the Mountain Oaks home under the Mountain Oaks' license with both of the licensees removed from the premises while the department investigated the allegations. He indicated that he made the

offer to preserve the Mountain Oaks business for the original licensees during the investigation and also to reduce the trauma to the residents from the disruption caused by the allegation.

Despite his offer, this operator did not take over the Mountain Oaks home. He stated that the department informed him that he must apply for a new Mountain Oaks license even if he administered the home only temporarily. This is because the department does not have procedures that allow it to temporarily license a substitute group home operator. Section 80035 of the California Code of Regulations requires a licensee to file a new application whenever certain changes in the conditions for a facility license occur, such as a change of licensee or of a facility's location. Section 80030 of the California Administrative Code allows the department to issue a six-month provisional license. However, this code does not include licensing a substitute licensee temporarily during an investigation.

The manager of the department's district office told us that she discouraged the second operator from running the home under the license that had been issued for Mountain Oaks because the second operator could become involved in any subsequent departmental action to revoke the license for Mountain Oaks. Section 1553 of the Health and Safety Code allows the department to pursue its administrative action against the original licensees and the facility even if the licensees have forfeited their license and no longer operate the group home.

According to the department's deputy director for the Legal Affairs Division, when the administrative action results in a license revocation, the allegation of sexual abuse against one of the licensees remains on the department's record if the administrative law judge upholds the revocation. Under Section 1520.3 of the Health and Safety Code, this record prevents a state licensing agency from considering new license applications for at least two years from persons having had their licenses revoked.

Conclusion

Although the Department of Social Services complied with state law and department procedures when it investigated allegations of sexual abuse against group home residents, it could have prepared its license revocations against Zanadu Group Home and Mountain Oaks Transitions Group Home, Inc., sooner. State law does not define the period of time in which the department must prepare its license revocations. However, the department could have shortened, by 6 to 26 weeks, the nine months

that it took to prepare the Zanadu case. In addition, the department could have shortened, by approximately 5 weeks, the four months that it took to prepare the Mountain Oaks case. Delay occurred in the two cases because the department neglected to ensure that its attorneys begin promptly to process the license revocations.

In addition, the department's procedures do not allow an adequate balance between protecting the health and safety of the children placed in the group home and preserving the licensee's business during an investigation of child abuse. Placement agencies that we contacted would typically remove their clients from group homes during an investigation of abuse to protect the clients from potential danger if the allegation is true and the accused is on the premises. However, when accused licensees of group homes lose their clients, they may go out of business whether or not the allegation is substantiated. Moreover, when placement agencies remove clients abruptly from group homes, the clients may suffer emotional trauma from the move.

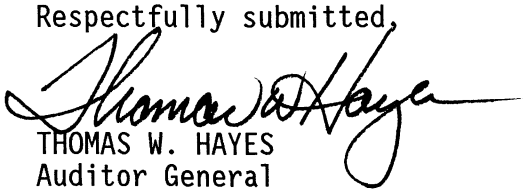
Recommendations

The department should begin preparing legal documents for administrative action promptly after its field investigations are complete to avoid delays that can adversely affect the department's case and to avoid potential danger to residents.

The department should establish procedures that allow an adequate balance between protecting the health and safety of clients placed in a community care facility and preserving the licensee's business during investigations of the licensee. The procedures, which the licensee would implement voluntarily, should reduce the trauma to the home's residents while still protecting their health and safety. For example, the department could allow, if an accused licensee so chooses, another licensed group home operator to temporarily administer and accept responsibility for the facility while the accused licensee is legally restrained from the premises until the department's administrative action is resolved.

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
Auditor General

Attachments

Department of Social Services' response to this report

ATTACHMENT 1

CHRONOLOGY OF ALLEGATIONS AND INVESTIGATION OF SEXUAL ABUSE AT TWO GROUP HOMES

Action	Zanadu	Mountain Oaks
Alleged abuse occurred	1981-83	July-October 1986
Allegations reported	May 15, 1986	December 19, 1986
Placement agencies removed clients	May 16 and 23, 1986	December 19, 1986
Police completed investigation	August 4, 1986	January 1987
District attorney(s) declined prosecution	September 19, 1986	March 10, 1987
Department requested attorney action	October 9, 1986	January 22, 1987
Attorney assigned	October 17, 1986	March 3, 1987
Attorney began work on the case	December 1986	March 9, 1987
Accusation to revoke sent to licensees	July 31, 1987	June 4, 1987
Hearings completed	May 10, 1988	May 6, 1988
Status as of June 7, 1988	Decision pending	Decision pending

ATTACHMENT 2

INVESTIGATIONS OF THE ALLEGATIONS

Investigation of Zanadu Group Home

On May 15, 1986, the Kern County Probation Department notified the department that allegations of sexual abuse occurring in 1981, 1982, and 1983 had been made to the sheriff's department by two former residents of Zanadu against a licensee of the home. Counties with clients placed as residents at Zanadu removed their clients after the allegations. As of May 15, 1986, the home served four additional private clients who remained in the facility. On May 29, 1986, the department received a second complaint, which charged the home with chronic overcapacity, intimidation, inadequate quality of food, excessive chores assigned to residents, and not following the prescribed program. The department conducted the required complaint visit at Zanadu on May 29, 1986, and reported that it had substantiated the four charges in the second complaint involving capacity, food, chores, and program.

Four law enforcement agencies ultimately received the reports of allegations of sexual abuse by a licensee of Zanadu. In addition to the Kern County Sheriff's Department, which received the original report, three other law enforcement agencies were involved because the residents alleged abuse at the Zanadu Group Home in Madera County and at least two other locations, one within the City of Fresno and one outside the city, in Fresno County. By June 3, 1986, almost three weeks after the allegations, the department evaluator reported that the three sheriff's offices turned the case over to the the Fresno Police Department to conduct the full investigation into the allegations. By August 4, 1986, the evaluator reported that the police department had essentially completed its investigation. Neither the police nor the department found further allegations of sexual abuse beyond those of the original two residents. By September 19, 1986, the district attorneys for Madera and Fresno counties had both declined to prosecute the licensee on criminal charges. The Fresno Police Department reported that the district attorneys did not prosecute because the statute of limitations had expired.

From May 16 to September 18, 1986, the department's evaluator assigned to investigate the case maintained contact with the law enforcement agencies to determine the course of their investigations. Section 1538(c) of the Health and Safety Code states that the department's on-site investigation in response to a complaint should not adversely affect the investigation of another agency. The evaluator did not interfere with the police investigation; however, she offered to assist law enforcement. On May 19, 1986, she offered to assist the Madera County Sheriff's Department. On June 20, 1986, she

offered to assist the Fresno Police Department by interviewing some of the past and current residents of the Zanadu Group Home to determine whether additional residents alleged any sexual abuse. The evaluator interviewed 17 of these residents.

Three weeks after the district attorneys declined to prosecute, the department sent the case to its legal division and recommended a license revocation and temporary suspension order. The department assigned an attorney on October 17, 1986. Over nine months later, on July 31, 1987, the deputy director for the department's Community Care Licensing Division signed the document seeking a license revocation against the two licensees doing business as Zanadu Group Home on the basis of alleged violations of personal rights, including alleged sexual abuse, overcapacity, false statements, insufficient staffing, and inaccurate recordkeeping. However, he decided not to pursue a temporary suspension order against Zanadu. He determined that the current residents did not appear to be in imminent danger, a major requirement for issuing a temporary suspension order.

In accordance with department procedures, the department notified local placement agencies of the potential problems at the time of the allegations at Zanadu. When the department renewed the Zanadu license in September of 1986 and 1987, it notified the licensee that the renewals did not prevent the department from taking administrative action at a later time, and in 1987, it also notified local placement agencies.

On July 31, 1987, the department sent the licensees of Zanadu the notice of its proposed license revocation. Two weeks later, the licensees requested a hearing on the department's administrative action. The hearings were completed on May 10, 1988. As of June 7, 1988, the revocation action was not resolved. While the case is pending, the home's license remains valid, and the group home is allowed to operate. As of September 9, 1987, five private and county clients resided in the home.

Investigation of Mountain Oaks
Transitions Group Home, Inc.

On November 12, 1986, a resident of Mountain Oaks alleged to a counselor at school that a licensee of the group home had sexually abused her during the previous months. On December 19, five weeks later, the counselor reported the allegation to a supervisor in the Shasta County child protective services agency. On the same day, the supervisor interviewed the alleged victim, notified the county sheriff's office, placement agencies, and the department's district office for community care licensing in Chico, and permanently removed all of the six residents before they could return to the group home after school.

According to the district office manager of the Community Care Licensing Division, the department did not conduct a site visit at the home within ten working days of the reported allegation because no children were in the home. In addition, a law enforcement investigation was underway. However, by the fifth working day after the reported allegations, the home's licensees met with department staff at the district office. The department's evaluator also interviewed two of the home's former residents in conjunction with an interview by staff from the county protective services agency. On January 12, 1987, the department's evaluator visited the home to discuss the allegations. He reported in the case file that the licensees' attorney advised them not to discuss the allegations; however, the licensees told us that they offered to speak provided the conversation was recorded.

The evaluator stated that he did not talk to other employees of the home or read the home's files during his investigation of the allegations. According to the department's chief of Audits and Investigations, although reading the facility's files and interviewing staff and suspects are standard investigation procedures, department investigators do not necessarily conduct these steps. He stated that often department investigators do not go into the facility if they believe enough evidence exists to recommend department action without a facility visit. The chief of Audits and Investigations indicated that the department is not required to pursue its investigations to the same extent as law enforcement agencies are required to pursue criminal investigations. Section 1551(b) of the Health and Safety Code requires that the department must prove its case in license revocations only by the "preponderance of the evidence" in the case.

On January 22, 1987, after its field investigation, the department requested its Legal Affairs Division to determine whether the State should take administrative action against the licensees of the Mountain Oaks home. On March 10, 1987, the county district attorney declined to prosecute on criminal charges because of insufficient evidence to sustain a conviction beyond a reasonable doubt. On May 20, 1987, the department's attorney recommended that the department file a license revocation so that the case could be heard by an administrative law judge. On June 4, 1987, over four months after the department's request to the Legal Affairs Division, the department issued a notice seeking license revocation for both of the original licensees doing business as "Mountain Oaks Transitional Group Home, Inc.," citing allegations of sexual abuse involving one of the licensees. The licensees requested a hearing on the department's proposed action to revoke the license. As of May 6, 1988, hearings for the case were completed. As of June 7, 1988, the proposed decision by the administrative law judge was pending.

STATE OF CALIFORNIA—HEALTH AND WELFARE AGENCY

DEPARTMENT OF SOCIAL SERVICES
744 P Street, Sacramento, CA 95814

June 21, 1988

Thomas W. Hayes
Auditor General
Office of the Auditor General
660 J Street, Suite 300
Sacramento, CA 95814

Dear Mr. Hayes:

THE DEPARTMENT OF SOCIAL SERVICES' COMPLIANCE WITH STATE LAWS AND REGULATIONS IN ITS INVESTIGATION OF ALLEGATIONS OF SEXUAL ABUSE AT TWO GROUP HOMES FOR TEENAGE GIRLS (P-578.2)

Mr. Clifford Allenby has asked me to respond to your June 15, 1988 letter which requested comments on a draft audit of the community care licensing enforcement program. The audit focuses on delays in filing accusations in two cases and makes some suggestions concerning ways to allow facilities to continue operating while allegations of abuse are investigated and during the revocation process with the alleged perpetrator voluntarily removed from the facility.

The facts in your audit relating to the delays in two cases are accurate. It is difficult to determine now how much time could have been saved had certain things happened in a more timely fashion. I agree that it is important both for the clients in care, the public, and the licensee that investigations and enforcement actions be pursued as expeditiously as possible. The enforcement program has been substantially strengthened in recent years and we are taking a number of steps to improve the process so that revocation actions can be resolved quickly. Our goal is to attempt to work with licensees to improve their operations to maintain compliance with state law. However, there are situations which arise in which the only prudent action is to seek revocation of the license. I don't believe the delays in two cases should detract from the overall success of our enforcement program.

You suggested that the Department offer specific procedures to enable an accused licensee to remove himself or herself from the operation of a group home while the investigation and hearing are

pending. In fact, licensees in this position and under other circumstances have on occasion entered into "management agreements" with other individuals enabling the contract administrator to run the facility for the duration of the agreement. Because the licensee retains responsibility for the operation of the facility, however, it would be difficult to insure, and perhaps unfair to insist, that the licensee remove himself or herself entirely from the operation of the facility during the contract period.

The substitution of a licensee would be feasible only in specific circumstances where the licensee is the clearly identifiable suspect of abuse; where removal of the licensee would cure the identified problems in the facility; and where someone qualified would be available to substitute and still not jeopardize the operation of any facility the substitute might already be operating. Any arrangement for a substitute licensee or administrator must deal with the question of where responsibility and liability should lie if there are problems in the facility while the substitute is in charge.

Assuming they could be approved by licensing, arrangements for temporary administration of a facility by an alternate licensee or administrator would allow a facility to remain open and retain its clients, at least in theory. However, whether placement agencies would continue their placements under these circumstances is a question beyond this Department's control, since we do not control the placement of clients in any community care facility. At least for foster children placed by counties and for developmentally disabled people placed by Regional Centers, the licensee may challenge a removal by requesting a hearing on the appropriateness of the action.

I will ask my staff to explore your suggestions to see if alternate arrangements in cases such as these would be permitted under current law and feasible in the program.

You may be interested in knowing that on June 17 we received a Proposed Decision in the Mountain Oaks case. The administrative law judge made findings in the Department's favor and proposes that the license be revoked.

We appreciate the opportunity to provide our comments on your report. If you have any questions, please feel free to contact me at (916) 445-2077 or have your staff contact Mr. Fred Miller, Deputy Director, Community Care Licensing Division at (916) 322-8538.

Sincerely,

LINDA S. McMAHON
Director