California State Auditor

BUREAU OF STATE AUDITS

Department of Social Services:

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

May 2006
2005-129

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CALIFORNIA STATE AUDITOR

ELAINE M. HOWLE
STATE AUDITOR

STEVEN M. HENDRICKSON
CHIEF DEPUTY STATE AUDITOR

May 25, 2006 2005-129

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

Dear Governor and Legislative Leaders:

As requested by the Joint Legislative Audit Committee, the Bureau of State Audits presents its audit report concerning the Department of Social Services' (department) oversight of licensed child care facilities.

This report concludes that the department has struggled to make required visits to the facilities and carry out its other monitoring responsibilities. For example, the department is not on track to meet its statutory requirement to visit each facility at least once every five years, even though the requirement is one of the least frequent in the nation. It began a three-phase effort in 2005 to rebuild its oversight activities for its licensing programs. Nevertheless, a question for the State's decision makers to consider is whether the level of monitoring required by statute, toward which the department is working with its rebuilding effort, is sufficient. In addition, our review of facility files at four regional offices found that the department usually conducted complaint visits within established deadlines but did not always complete the investigations within deadlines. We also found that the department did not always determine whether child care facilities corrected the deficiencies it identified during its visits to facilities. Further, our review identified that the department could increase its use of civil penalties as a response to health and safety violations. Finally, although it appropriately prioritized and generally ensured that legal cases were processed within expected time frames, its regional offices did not always adequately enforce legal actions against licensed child care facilities.

Respectfully submitted,

Elaine M. Howle

ELAINE M. HOWLE
State Auditor

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SUMMARY

Audit Highlights . . .

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

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

RESULTS IN BRIEF

The Department of Social Services (department), through the child care program in its community care licensing division, is responsible for monitoring licensed child care facilities—child care centers (centers) and family child care homes (homes)—and investigating complaints against those facilities. However, the department has struggled to make required visits to the facilities and carry out its other monitoring responsibilities. For example, the department is not on track to meet its statutory requirement to visit each facility at least once every five years, even though the requirement is among the least frequent in the nation. Further, although it is tracking other statutory visit requirements, the data it uses to do so have various problems, and thus the department's assessment of its progress in meeting the requirements may not be accurate.

The department points to reduced resources in recent years stemming from the State's budget shortfall as the reason for its inability to fulfill all of its monitoring responsibilities. Thus, the department has had to prioritize among the various oversight activities it conducts as part of its licensing programs, including its child care program, to focus on those that provide the most direct protections, such as investigating complaints against child care facilities. At the same time, it acknowledged that other important activities have been delayed or eliminated.

In the spring of 2005, the department began a three-phase effort to rebuild its oversight activities for its licensing programs. As of March 2006, the department was in the initial phase, which focuses on rebuilding the "foundation" of its monitoring program through activities such as hiring staff and developing management data. The subsequent phases, which aim to increase monitoring activities and analyze information that is expected to result from the increased level of monitoring, are dependent on proposed funding. Nevertheless, a question for the State's decision makers to consider is whether the level of monitoring required by statute, toward which the department is working with its rebuilding effort, is sufficient.

As the department rebuilds its child care oversight function, it is also important for it to evaluate which of its existing oversight processes are working well and which require improvement. The

department stated that it considers conducting and completing complaint investigations in a timely manner to be one of its highest priorities. Our review found that the department has established a process for addressing complaints. Our testing of a sample of complaints at four regional offices indicated that the department usually conducted complaint visits within established deadlines but did not always complete the investigations within deadlines. In addition, the department could have taken additional action to resolve some of the complaint allegations we reviewed that it found to be inconclusive.

Further, the department did not always determine whether child care facilities corrected the deficiencies it identified during its visits to facilities, although our review indicated that the department was more effective in following up on deficiencies noted during complaint visits than it was for those identified during its routine periodic inspections. Finally, we noted various instances in which the department concluded that facilities had taken corrective action, but the agreed-upon actions were not verifiable or measurable.

The department appropriately monitored the activities of the six counties with which it contracts to license and monitor homes within their boundaries. However, it has yet to develop sufficient automated management information that will allow it to effectively monitor the regional offices of its child care program, which carry out most of the department's oversight of licensed child care facilities. As a result, the department has limited assurance that these regional offices are consistently complying with established procedures. In addition, the department has established a process to inform parents of certain problems it identifies during its visits to facilities. However, although it stated that it has begun the necessary planning to make nonconfidential information regarding its monitoring visits more readily available to the public by placing it on its Web site, implementation will be dependent on funding.

The department employs a progressive system of enforcement through the regional offices of its child care program and its legal division to address health and safety violations by child care facilities. The enforcement measures include assessing civil penalties for violations of state laws and regulations, holding noncompliance conferences with licensees after unsuccessfully attempting to gain compliance, and taking legal action, if necessary.

However, our review revealed that the department needs to improve its enforcement activities. In particular, we found that the department could increase its use of civil penalties as a response to health and safety violations by facilities. For example, we found that the department assessed civil penalties in a more limited manner for homes than it did for centers because regulations for homes establish civil penalties only for specific violations. In addition, we found several instances at four regional offices in which the department did not follow its guidance regarding the use of noncompliance conferences. Specifically, we noted instances in which the department did not conduct the conferences promptly enough, considering the severity of the health and safety violations. For example, the department did not require a licensee to attend a noncompliance conference until nearly five months after an incident in which a child was left unattended in the back of a car for two hours.

Although our review of selected legal cases found that the department appropriately prioritized the cases and generally ensured that its legal division processed the cases within expected time frames, the regional offices did not always adequately enforce legal actions against licensed child care facilities. For example, we found that for the cases we reviewed, regional offices often did not make visits as required after the facilities' licenses were revoked to ensure that the facilities were no longer operating.

RECOMMENDATIONS

To ensure that the department continues to make monitoring visits, including periodic inspections and complaint visits, and carries out its other required responsibilities for child care facilities, the department should:

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

- Continue its efforts to rebuild the oversight operations of its child care program and assess the sufficiency of its current monitoring efforts and statutory requirements to ensure the health and safety of children in child care facilities.

- Complete complaint investigations within its established deadlines. In addition, the department should revise its policies to identify specific actions its child care program staff could take to reduce the number of inconclusive complaint findings.

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

- Develop sufficient automated management information to facilitate the effective oversight of its child care program regional offices.

- Continue its efforts to make all nonconfidential information about its monitoring visits more readily available to the public.

To improve its enforcement actions in order to effectively address health and safety violations by child care facilities, the department should:

- Consider proposing statutes or regulations requiring it to assess civil penalties on homes for additional types of violations.

- Clarify its direction to regional office staff to help ensure that they are using noncompliance conferences promptly and in appropriate instances. In addition, the department should periodically review the regional offices' use of noncompliance conferences to ensure that they are consistently following established policies.

- Ensure that the regional offices adequately enforce legal actions against facilities, such as performing visits within the required 90 days after the facilities' licenses are revoked to ensure that the facilities are no longer operating.

AGENCY COMMENTS

The department agreed with our recommendations and stated that it welcomed the audit results as important contributions to its enforcement policies that will help increase protections for children throughout the State. ■

INTRODUCTION

BACKGROUND

The community care licensing division of the Department of Social Services (department) is responsible for regulating and protecting the health and safety of children and adults in out-of-home care. Specifically, the division licenses and monitors child, adult, and senior care facilities. The child care program within the community care licensing division provides child care licensing services and performs monitoring across the State.

Types of Child Care Facilities

Child care centers—These facilities are usually located in a commercial setting. By law, staff are generally trained in early childhood education.

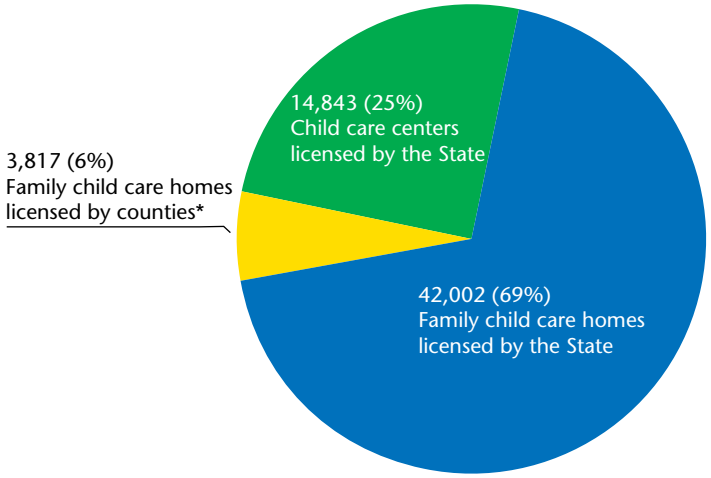
Family child care homes—Child care is provided in a private residence with a homelike setting. Child care homes are licensed to serve a maximum of 14 children (eight children or less in "small homes" and seven to 14 in "large homes"). Under the law, staff are required to have only minimal training.

A child care facility license is not needed if a person cares for a relative's children or children from only one family unrelated to the person, such as a neighbor's children. In other circumstances, state law requires an individual to have a license to provide child care. The number of children cared for further defines the facility type and the laws and regulations the child care facility owner or operator must follow.

The child care program operates through 12 regional offices—six in Northern California and six in Southern California—that report to the child care program administrator. Although the State licenses the majority of child care facilities, the law gives the department the option of contracting with counties to license certain child care facilities within their boundaries. Currently, six counties have contracted with the department; however, the counties' licensing authority is limited to family child care homes (homes). The regional offices license all child care centers (centers) in the State. Despite the six counties' limited licensing authority, the regional offices and the counties have similar responsibilities to issue child care facility licenses and to ensure that the facilities they license comply with applicable laws and regulations. As Figure 1 on the following page shows, as of February 2006, there were more than 60,000 licensed child care facilities in the State.

FIGURE 1

Licensed Child Care Facilities as of February 2006



Source: Department of Social Services' community care licensing division.

* The counties are Del Norte, Inyo, Marin, Mendocino, Sacramento, and Tehama.

THE DEPARTMENT'S PROCESSES FOR LICENSING FACILITIES, MONITORING COMPLIANCE, AND TAKING NEEDED LEGAL ACTION

The department, through its 12 regional child care program offices and the six counties with which it contracts, uses a formal screening process to license homes and centers. The licensing process begins with an orientation for potential child care facility licensees outlining the licensee's roles and responsibilities. The process also entails a mandatory criminal record check, conducted by the department's Caregiver Background Check Bureau, a physical inspection of the proposed facility, and a review of the license application. Once the department or county issues a facility license, it is valid until the licensee closes or moves the facility, or until the department takes action to suspend or revoke the license.

After issuing a child care facility license, the department conducts several kinds of visits and evaluations to ensure that a facility is complying with established licensing laws and regulations. In particular, state law requires the department to visit facilities annually in certain circumstances and to conduct

random visits of at least 10 percent of the remaining facilities each year. State law further requires that each facility be visited at least once every five years. The department's licensing program analysts visit facilities to determine whether they are complying with licensing laws and regulations and, when necessary, consult with the licensee verbally or in writing, issue citations, or assess penalties.

The department also performs several other types of visits and evaluations—including prelicensing evaluations, case management visits, and complaint visits—to ensure that each licensed child care facility is operating in a safe and healthful manner. The department considers complaint visits to be one of its highest priorities. A complaint visit is made in response to allegations by parents or others that a licensee is violating licensing laws or regulations. State law requires the department to visit the facility within 10 days after receiving the complaint. If the complaint is substantiated, the department and licensee prepare a plan to correct the deficiency. The department is then required to follow up to make certain that the licensee has made the necessary corrections. In the child care program, specialized staff investigate allegations of serious physical and sexual abuse.

The department has a system of progressive disciplinary actions against child care facility licensees, employees, or others who demonstrate that they do not comply with state laws and regulations. After repeated violations, or a single incident if deemed necessary, the department can hold a noncompliance conference with a licensee and take legal action in the form of probation, exclusion from child care facilities, or license revocation. When taking legal action, the department's legal division must first file an accusation against the individual who allegedly committed the violation. That person has two options: either request a judge, an impartial third party, to hear the case in a formal trial-like setting and render a decision, or allow the department to impose disciplinary actions by default. If the person requests a hearing, at any time before the judge renders a decision, the individual may try to negotiate a settlement with the department. The judge's decision is binding, and the department is responsible for enforcing it.

PREVIOUS REPORTS ISSUED BY THE BUREAU OF STATE AUDITS

In August 2000, we issued a report titled *Department of Social Services: To Ensure Safe, Licensed Child Care Facilities, It Needs to More Diligently Assess Criminal Histories, Monitor Facilities, and Enforce Disciplinary Decisions*. In the report, we assessed the department's policies and practices for licensing and monitoring child care facilities. We studied child care facility licensees, employees, and adult residents with criminal histories to whom the department had granted exemptions. Our review focused on the department's direct licensing and monitoring activities and how the department ensures that the counties license and monitor child care homes in accordance with state laws and regulations.

Some of the key findings from the report that are relevant to the scope of this audit were that the department was lax in ensuring that substantiated complaints were corrected, facility evaluations were not always performed as required, the department did not periodically and consistently monitor licensing operations in the counties that it contracted with to perform such operations, the department did not periodically and consistently assess the operations of its district offices,[1] and department staff did not always consistently and diligently enforce legal decisions.

As a result of these findings, we recommended that the department make certain that all necessary complaint follow-ups occur and that it conduct facility evaluations within the required timelines, periodically review each county's child care facility licensing operations, periodically and consistently assess the operations of its district offices, and enforce legal decisions promptly and consistently.

In August 2003, we issued a report titled *Department of Social Services: Continuing Weaknesses in the Department's Community Care Licensing Programs May Put the Health and Safety of Vulnerable Clients at Risk*. The report was broader in scope than the previous one and included an assessment of the department's policies and practices for licensing and monitoring adult care, foster care, and senior care facilities. We included in our study facility licensees, employees, and adult nonclient residents with criminal histories to whom the department had granted exemptions. We also reviewed the operations of selected state-contracted counties that license foster family homes and

[1] At the time of the audit, 13 district offices reported to four regional offices. District offices no longer exist, and there are now 12 regional offices.

examined how the department ensures that the counties license and monitor those homes in accordance with state laws and regulations. Finally, we followed up on the recommendations that we made in the August 2000 report.

Some of the key findings from the report that are relevant to the scope of this audit were that the department continued to need improvement in how it investigated complaints; the department still did not always perform periodic on-site facility evaluations as required; and the department's enforcement of legal decisions was not always timely, consistent, or thorough.

We recommended that the department continue to emphasize complaint investigations over other duties; require analysts to begin investigations within 10 days of receiving complaints and, whenever possible, to resolve investigations within 90 days; require supervisors to review evidence that facilities had taken corrective action before signing off on a complaint; and conduct follow-up visits to ensure that enforcement actions against facilities are carried out and document its follow-up.

SCOPE AND METHODOLOGY

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

To understand the department's process for providing oversight of licensed child care facilities, we reviewed the relevant laws and regulations and the department's policies for overseeing the facilities. To determine whether the department was following its oversight process, we reviewed four of its 12 regional offices: Bay Area, Inland Empire, Los Angeles Northwest, and River City.

Although the department also contracts with six counties to license and monitor child care homes, our review focused on the department's direct monitoring activities and on how it ensures that the counties monitor the homes in accordance with state laws and regulations.

We assessed the department's progress in meeting inspection requirements by examining the department's statistics on the number of periodic inspection visits made compared to the number of visits required by state law for fiscal years 2002–03 through 2004–05. We also examined the department's projections for fiscal year 2005–06 based on its actual data through December 2005. For the period from July 1, 2002 through December 31, 2005, we analyzed the process the department used to determine the number of visits it needed to make to meet the inspections required by state law. We noted that the department did not calculate its visits needed before each of the fiscal years for which it made its calculations. In addition, we were unable to verify all of the information the department used in its calculations because it did not retain some data. Further, we analyzed the department's electronic data supporting the periodic inspections it reported as being made for the same three and a half year period. Generally accepted government auditing standards require us to assess the reliability of computer-processed data. Based on our analysis and further research by the department, we concluded that the data were not sufficiently reliable, and the extent of the misstatement is unknown. Nevertheless, they are the only available data. We present the department's statistics as well as the concerns we have with the data in Chapter 1.

As we considered the department's efforts in making periodic inspections, we learned that the department was in the midst of rebuilding its child care oversight function. We interviewed management and reviewed relevant documentation to assess where the department was in its rebuilding effort and what it plans to accomplish with regard to periodic inspections and other monitoring activities. We also reviewed budgetary information on past and proposed resources available to the department's child care program.

To review its process for handling complaints about facilities, we reviewed the department's policies for investigating and resolving complaints. For a sample of complaints at the four regional offices we reviewed, we determined whether the department had conducted complaint visits and performed

investigations within established deadlines. In addition, we reviewed relevant documentation and interviewed staff to determine whether the department could have taken additional actions to resolve complaint allegations it found to be inconclusive. We also assessed whether the department ensured that facilities corrected deficiencies arising from complaint visits, and we compared the results with a similar analysis of deficiencies arising from a sample of periodic inspections that we reviewed.

We examined how the department ensures that the counties it contracts with monitor homes in accordance with state laws and regulations by evaluating the assessment tool the department uses and reviewing a few instances in which the tool was used. Also, we considered the various ways in which the department monitors its regional offices, including the extent to which it uses management information. During our reviews of deficiencies cited during periodic inspections and complaint visits, we examined whether the department adequately categorized health and safety risks identified at facilities. Further, we considered the ways in which the department informs parents and others of problems it finds at facilities. In doing so, we considered practices that other states use to inform the public of such problems.

Finally, we obtained an understanding of the department's disciplinary process, including its use of civil penalties, noncompliance conferences, and legal action. We reviewed the circumstances under which state law and regulations require the department to impose civil penalties and assessed the extent, based on a sample of cases at the four regional offices we reviewed, to which the department used civil penalties. We also reviewed the department's guidance for determining when a noncompliance conference is called for and evaluated whether the department was following that guidance. Similarly, we reviewed the department's guidance for determining when action to revoke a facility's license is called for and considered the extent to which regional offices employed a key control—consulting the department's legal division. Further, we examined a sample of legal action cases at the four regional offices we reviewed to ensure that the legal division processed cases promptly and in accordance with its priorities. We also determined the steps the department took to enforce the legal action decisions, and examined whether these steps were taken promptly and were sufficient to ensure that facilities complied with the decisions. ■

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CHAPTER 1

As the Department Rebuilds Its Child Care Oversight, It Must Continue to Improve Its Monitoring Processes

CHAPTER SUMMARY

The Department of Social Services (department) has struggled with its responsibilities for monitoring the child care facilities it licenses and is not on track to meet its statutory requirement to visit each facility at least once every five years. The department points to reduced resources in recent years stemming from the State's budget shortfall as the reason for its inability to fulfill these responsibilities. It has had to prioritize its various oversight activities to focus on those that provide the most direct protections. At the same time, it acknowledged that other important activities have been delayed or eliminated.

In the spring of 2005, the department began a three-phase effort to rebuild its oversight of its licensing programs. As of March 2006, the department was in the initial phase of this effort, which includes activities such as hiring staff and developing management data. The subsequent phases, which aim to increase monitoring activities and analyze the resulting information, are dependent on proposed funding. However, a question for the State's decision makers to consider is whether the level of monitoring that the department is working toward is sufficient.

The department has stated that it considers conducting and completing complaint investigations in a timely manner to be one of its highest priorities. Our review found that the department has an established process for addressing complaints, and our testing of a sample of complaints at four regional offices indicated that the department usually conducted complaint visits within established deadlines. However, the department did not always complete investigations of the complaints it received within deadlines. In addition, it could have taken additional action to resolve some of the complaint allegations we reviewed that the department found to be inconclusive. Further, the department did not always determine whether child care facilities had corrected the deficiencies

identified during its visits to facilities, although our review indicated it was more effective in following up on deficiencies noted during complaint visits than it was for those identified during its routine periodic inspections. Finally, we noted various instances in which the department concluded that corrective action had been taken, but the agreed-upon actions were not verifiable or measurable.

The department appropriately monitored the activities of the six counties with which it contracts to license and monitor homes within their boundaries. However, it has yet to develop sufficient automated management information that will allow it to effectively monitor its regional offices. As a result, the department has limited assurance that its regional offices are consistently complying with established procedures. Finally, the department has established a process to inform parents of certain problems it identifies during its visits to facilities, but it has yet to make such information readily available to the public. Other states have provided varying degrees of compliance information to the public.

THE DEPARTMENT HAS STRUGGLED WITH MAKING REQUIRED VISITS

The department conducts unannounced periodic inspections of child care facilities to evaluate whether the facilities comply with licensing laws and regulations. To assess a child care facility's compliance during an inspection, the department visually checks areas of the facility accessible to children, observes the care and supervision of children, and reviews staff and children's files. The department then discusses the results of its inspection with facility representatives, including any deficiencies that need to be corrected.

Until August 2003, state law required the department to conduct inspections of centers annually and of homes every three years.

Until August 2003, state law required the department to conduct inspections of child care centers (centers) annually and of family child care homes (homes) every three years. According to the department, from fiscal year 2001–02 until mid-fiscal year 2003–04, the department used focused visits to make its periodic inspections. During a focused visit, the licensing program analyst (analyst) would review only certain key high-risk areas such as criminal record clearances, violations of children's personal rights, and care and supervision. The department used focused visits to maximize the number of visits it could make

during a period of declining resources. It stated that before it implemented this approach, it performed comprehensive visits of the facilities.

State law requires an annual unannounced visit to a child care facility when:

- A facility's license is on probation.
- The terms of agreement in a facility's compliance plan require an annual evaluation.
- An accusation against a licensee is pending.
- The department must verify that a person ordered out of a facility is no longer at the facility.

State law enacted in August 2003 established new requirements for how often the department should conduct periodic inspections of child care facilities. Under this new law, the department is specifically required to make unannounced visits to certain facilities annually, as shown in the text box. The department refers to these inspections as required visits. In addition, the law requires the department to make unannounced visits to a random sample of at least 10 percent of the remaining facilities each year. These visits are known as random visits. The requirements further state that the department must visit each child care facility at least once every five years. According to the department, with the establishment of random and required visits, it resumed performing comprehensive reviews of facilities' compliance with laws and regulations and has conducted this type of review since November 2003.

The department conducts other types of monitoring visits—most notably complaint visits—in addition to the required and random visits. However, it does not consider these other visits as meeting its statutory requirement to visit each child care facility at least once every five years. The department stated that when it conducts a complaint visit, it focuses on the specific issues identified in the complaint. Thus, the department believes that counting complaint visits toward the statutory requirement would not reflect the Legislature's intention in establishing the requirement.

Nevertheless, as of March 2006, the department is conducting a pilot project to consider whether it is appropriate to recommend counting complaint and other visits toward the "once every five years" requirement. In the pilot project, the department has added a modified comprehensive evaluation component to its complaint visits to focus on critical risk factors such as whether a facility does not have criminal record clearances for all adults, has obvious hazards, or has not locked up all poisons. Two of the department's 12 child care regional offices are participating in the pilot project. According to the department, the pilot project will end in May 2006, after which it plans to evaluate the data collected to determine the effectiveness and efficiencies of the project.

The department has focused its efforts on trying to conduct those facility visits that are specifically required by state law and those necessary to meet the 10 percent random sample target. Nevertheless, the department did not meet those statutory requirements for fiscal year 2004–05, the only full year that has elapsed since the new requirements were enacted. Specifically, as Table 1 shows, the department reported that it performed 5,030 (68 percent) of the 7,363 specifically required or random visits needed in fiscal year 2004–05. As of March 2006, the department expects to exceed the requirements for fiscal year 2005–06.

TABLE 1

A Comparison of Periodic Inspection Visits Needed to Visits Made for Fiscal Years 2002–03 Through 2005–06

	Focused Visit Approach		Comprehensive Visit Approach		
	2002–03	2003–04	2004–05*	2005–06 (first six months)	2005–06 (projected)
Required visits needed†			1,596	884	1,768
Random visits needed†			5,767	2,726	5,452
Total visits needed	**28,486**	**12,313**	**7,363**	**3,610**	**7,220**
Annual visits made‡	7,348	1,260			
Triennial visits made‡	6,271	1,072			
Required visits made	21§	480	1,352	787	1,574
Random visits made	29§	1,549	3,678	3,066	6,132
Total visits made	**13,669**	**4,361**	**5,030**	**3,853**	**7,706**
Percentage of visits made to visits needed	48%	35%	68%	107%	107%

Source: Department of Social Services' community care licensing division.

Note: As discussed further in the chapter, these statistics are based on the department's data, which are not sufficiently reliable. Thus, the statistics may not accurately reflect the department's progress in meeting statutory requirements.

* The department stated that it implemented random and required visits in November 2003. However, because of implementation difficulties, it did not specifically identify the number of random and required visits it needed to make until fiscal year 2004–05, which was the first full year under its new visit approach.

† The number of required visits needed represents the visits the department is specifically required to make under state law, as described in the text box presented earlier. The number of random visits represents the visits the department has calculated it needs to make to meet the 10 percent random sample required by state law. The number of visits needed does not reflect what is necessary to meet the statutory requirement that the department visit facilities at least once every five years.

‡ In compliance with statutes in effect at the time, the department made annual visits to centers and triennial visits to homes.

§ According to the department, although these visits occurred during fiscal year 2002–03, they were entered into the department's database after it began making required and random visits in November 2003, and thus were classified as such. The extent to which similar misclassifications occurred in the first few months of fiscal year 2003–04 is unknown.

The Data the Department Uses to Track Inspection Visits Are Not Sufficiently Reliable

The data the department uses to record and track inspection visits are not reliable and therefore may not accurately reflect its progress toward meeting statutory requirements. To substantiate inspection visit statistics the department provided the Legislature in November 2005, we requested that the department provide us with the data from its database system. In analyzing the data, we found numerous instances of multiple visits being made to the same facility on the same day. For example, the data showed that one facility received as many as six visits on October 11, 2005. When we questioned the department, it informed us that duplicate visits can inadvertently be entered into the system. The department explained that when analysts save a visit report and then continue to edit the report, a new copy is created in the system. The department agreed that these duplicate visits were not valid and should not be counted toward meeting its statutory requirements. We then removed all same-day duplicate visits from the data to arrive at the number of visits shown in Table 1.

In analyzing the department's data, we found numerous instances of multiple visits being made to the same facility the same day.

In addition to the duplicate visits, there were additional instances in which invalid visits were recorded in the system. We found numerous instances where the department's data indicated that a facility received more than one inspection visit in the same fiscal year. For example, the data showed that one facility received an inspection visit on May 16, 2003. That same facility then received an additional inspection visit 21 days later, on June 6, 2003. According to the department, in this instance the inspection visit took more than one day to complete, and the analyst submitted reports for each visit. A situation such as this would not create a problem if the department was simply using the system as a method for keeping track of the work its analysts perform. However, because the statutory requirement focuses on facilities visited rather than visits performed, it causes a misstatement. Specifically, in this situation, the department counted this as two facilities visited rather than one facility visited.

In addition, after researching some of the concerns we noted, the department informed us of instances in which deferred visits were reported in the system but were still counted as visits made. Deferred visits are those in which the department was scheduled to perform a visit but did not, instead putting it on hold until a later date. The department began allowing staff to defer visits to facilities meeting certain criteria in October 2002, in an effort to decrease its workload in light of reduced staffing. Further, the department provided us with other examples of invalid visits

being reported, such as when a visit was attempted but not made. However, due to limitations in the data, we were not able to quantify the number of invalid visits and remove them from Table 1 without also removing valid visits.

In addition, we found approximately 3,000 instances in fiscal year 2002–03 and more than 1,100 instances in fiscal year 2003–04 in which the department made some type of visit but did not specify in its system the type that was made. Thus, the department does not know whether these visits were periodic inspections or some other type of visit, such as a prelicensing or case management visit. To the extent that these unidentified visits were periodic inspections, it may help offset any overstatement resulting from the inclusion of invalid visits. The department told us that it plans to further research the various concerns we noted with its data, and make any modifications necessary to use the data as a reliable source for assessing its progress in meeting statutory visit requirements. Further, the department plans to provide data entry training to its staff.

The Department Is Not on Track to Meet an Additional Statutory Requirement

Our review also found that the department is not currently on track to meet the statutory requirement of making a visit at least once every five years. To meet that requirement, one would expect to see that the department was, on average, conducting visits to approximately 20 percent of the facilities annually. However, the 5,030 facilities the department reported as visited in fiscal year 2004–05 represented only 8.5 percent of the more than 59,000 licensed child care facilities in the State during the same period.

As of March 2006, the department has yet to start tracking the "once every five years" requirement to determine the facilities it needs to visit.

Further, although as of March 2006 the department is midway through the first five-year period, it has yet to start tracking the "once every five years" requirement to determine the facilities it needs to visit so that it can ensure that all are visited within the period. The five-year period began in mid-2003 and will end in mid-2008. The department stated that until recently it had no system in place to capture the necessary data. Although it stated that it now has a system to capture and report the data in a systematic, automated fashion, the department believes it lacks the staff to make the visits needed to meet the statutory requirement. The department indicated that when it receives more staff, it plans to explore methods for tracking the requirement and assessing

which facilities have not yet had a visit. The department plans to begin its efforts by generating a report by December 2006 that will show all facilities that have not received a periodic inspection since July 2003. However, the department pointed out that it faces a challenge in monitoring and tracking homes because of frequent turnover among these child care providers. According to data it provided to us for the years from 1996 to 2003, between 22 percent and 26 percent of its licensed homes stop providing services annually.

California's current "once every five years" requirement is one of the least frequent in the nation.

The department's performance in conducting these periodic inspections is even more of a concern when one considers that California's current "once every five years" requirement is one of the least frequent in the nation. According to a September 2004 Government Accountability Office (GAO) report titled *CHILD CARE: State Efforts to Enforce Safety and Health Requirements*, 41 states require that centers be inspected at least once a year and 37 states require that homes be visited at least once every two years.[2] The laws in place in California before its new requirements were established in 2003 were more consistent with those in other states. As we mentioned previously, the prior laws called for annual visits to centers and visits to homes every three years. However, the department was not successful in meeting those more stringent requirements. For example, as shown previously in Table 1, the department reported that it made only 48 percent of the visits needed for fiscal year 2002–03, the last full year in which the previous statutory requirement was in place. Additionally, as we discussed previously, the visits the department made during that time period were not comprehensive.

It is important to recognize that periodic inspections are not the only visits the department makes to child care facilities. For example, the department reports that it performs thousands of complaint visits each year. However, these visits are reactive in nature and focus on the specific issues identified in the complaints. They do not replace periodic inspections, which are intended to be proactive and comprehensive in nature and represent a critical component of an effective monitoring approach.

[2] The GAO report did not address whether states with more frequent routine visits to child care facilities experienced fewer complaints or other indicators of problems.

The Department Points to a Lack of Resources in Recent Years as the Reason for Its Inability to Carry Out Its Various Monitoring Duties

According to the department, in the past five years the community care licensing division, which oversees the child care program as well as various other licensing programs, has felt the impact of California's budget shortfall. Table 2 shows that for fiscal years 2001–02 through 2004–05, the number of positions authorized for child care oversight fell from 439 to 335, a 24 percent decrease. Over the same period, the number of filled positions declined from 409 to 289, a 29 percent decrease. As Table 2 also shows, the department began to rebuild its child care oversight in fiscal year 2005–06, when it increased from 335 to 340 the number of authorized positions and from 289 to 314 the number of filled positions. Further, the Governor's Budget issued in January 2006 has proposed 385 authorized positions for fiscal year 2006–07, a 45-position increase over the 340 positions authorized for fiscal year 2005–06. Analyst positions account for 36.5 of the proposed 45-position increase.

TABLE 2

Child Care Oversight Positions for Fiscal Years 2001–02 Through 2006–07

Fiscal Year	Number of Authorized Positions	Number of Filled Positions	Number of Unfilled Positions
2001–02*	439	409	30
2002–03	428	366	62
2003–04	404	323	81
2004–05	335	289	46
2005–06	340	314†	26
2006–07	385‡	NA	NA

Sources: Department of Social Services' fiscal year 2001–02 analysis and fiscal year 2005–06 midyear estimate, California salaries and wages supplements, and the fiscal year 2006–07 Governor's Budget.

Note: This table reflects the total positions associated with the child care program, including management analysts, clerical staff, and others. It does not include certain positions involved with enforcement activities, such as the legal division.

NA = Not applicable.

* The department's organization structure did not specifically separate staffing for the child care program in fiscal year 2001–02. The department compiled the numbers of authorized and filled positions using data available from fiscal year 2001–02.

† The department estimated the number of filled positions as of midyear fiscal year 2005–06.

‡ The Governor's Budget issued in January 2006 has proposed these authorized positions for fiscal year 2006–07.

Table 2 also shows that the number of unfilled positions increased dramatically over three fiscal years, from 30 in fiscal year 2001–02 to 81 in fiscal year 2003–04. The number of unfilled positions has declined in subsequent fiscal years.

The department points to staff cuts, hiring freezes, and eliminations of vacant positions as being factors that significantly decreased the staff resources available for monitoring its licensing programs, including the child care program. For example, the department indicated that it lost vacant positions as a result of the fiscal year 2002–03 Budget Act, Section 31.60, which required the Department of Finance to abolish at least 6,000 positions statewide that were vacant as of June 30, 2002. In addition, the department stated that during the State's hiring freeze, it was unsuccessful in its requests for exemption for its analysts and other staff. The decline in resources, coupled with a growth in the number of child care facilities, has created challenges for the department in carrying out its responsibilities. To reduce its workload in conjunction with the reductions in its staff, the department eliminated, revised, or reduced certain functions while giving other functions a higher priority.

To reduce its workload in conjunction with staff reductions, the department eliminated, revised, or reduced certain functions while giving other functions a higher priority.

In particular, in October 2002, after the department was unsuccessful in getting an exemption from the State's hiring freeze, it identified the fundamental activities that it needed in order to provide the most direct protections for its clients in community care facilities. These priority activities were as follows:

- Conduct and complete all complaint investigations in a timely manner.
- Investigate all serious incident reports.
- Ensure completion of all plans of correction for serious violations.
- Conduct orientations and process applications.
- Conduct prelicensing visits to ensure compliance before issuing a license.
- Conduct criminal background checks and ensure that persons excluded or ordered out of facilities are gone.
- Support efficient and effective use of legal action processes.

However, the department noted that focusing on these priorities meant that some other important licensing activities were either delayed or eliminated. For example, it delayed facility visits and shifted the responsibility for conducting certain types of visits to staff who were not analysts. In addition, with continued reductions to its budget in 2003, the department significantly reduced staff in its child care advocate program. The Legislature created the program in 1984 to promote the delivery of quality child care in California. Child care advocates provide a link between the department and communities by providing information to the public and parents about child care licensing, acting as a liaison to local child care resource and referral agencies,[3] and assisting in the coordination of complaints and concerns on behalf of children in child care. According to the department, prior to the budget reductions, each of the 12 child care regional offices employed a child care program advocate. With the budget constraints, the department reduced the number of child care advocates to two.

More significantly, the number of the department's analysts declined from more than 235 positions in fiscal year 2001–02 to 182 positions in fiscal year 2004–05, a 23 percent decrease. Even though the department estimates that it will increase the number of analysts to 198 positions in fiscal year 2005–06, this number is less than the staffing level the department had in fiscal year 2001–02. The department's workload per analyst is also considered to be relatively high. The GAO stated in its September 2004 report that the recommended caseload was on average no more than 75 child care facilities per staff member. In 2003, according to the report, the State's caseload was 241 facilities per staff member conducting inspections, among the highest in the nation.[4] In preparing its fiscal year 2005–06 budget, the department has identified caseload standards of 309 homes per analyst or 198 centers per analyst. We recognize that the extent of an analyst's responsibilities plays a role in the caseload an analyst can handle. The GAO report does not identify the responsibilities associated with the average of 75 child care facilities per staff member. Nevertheless, there is a significant difference between the recommended caseload and the department's caseload standards.

The department's workload per analyst is considered to be relatively high.

[3] Local child care resource and referral agencies, which are located in each county in California, support parents, providers, and local communities in finding, planning for, and providing affordable quality child care.

[4] The GAO calculated the State's caseload as the number of child care facilities divided by the number of full-time equivalent staff for child care licensing and enforcement.

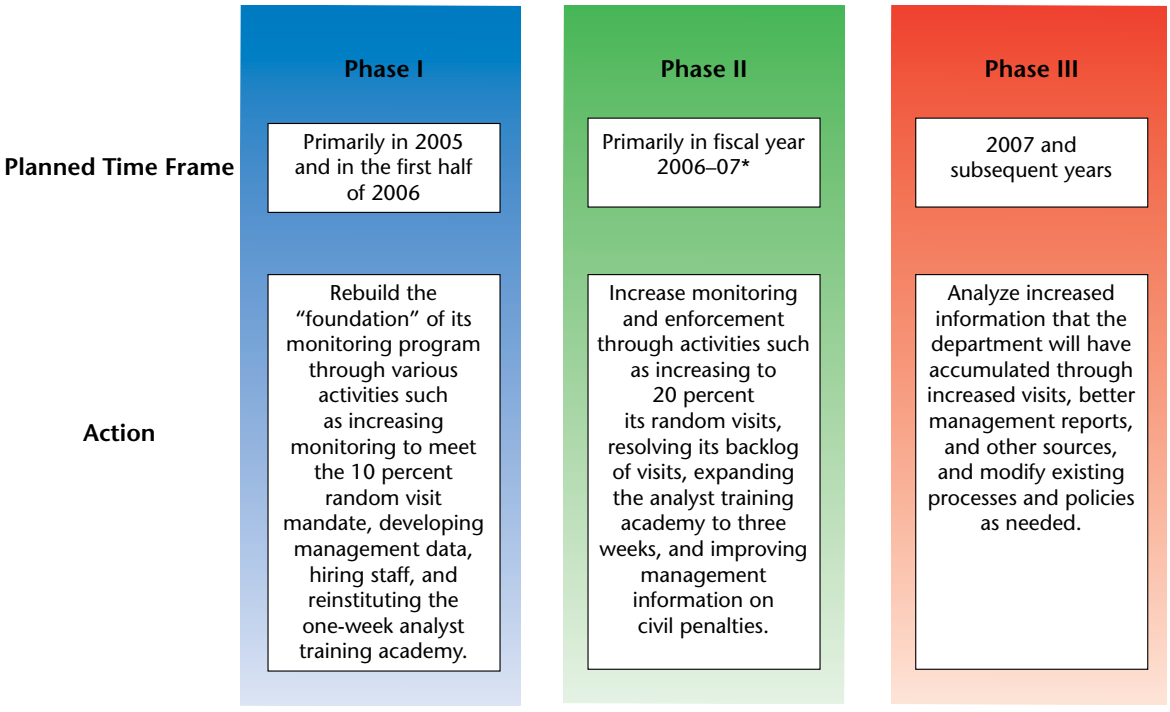
In an effort to address the caseloads of its analysts, the Governor's Budget issued in January 2006 proposes to increase the number of the department's analysts by 36.5 positions for fiscal year 2006–07. However, 16 (44 percent) of these positions are limited-term positions that are set to expire in December 2008. According to the department, it proposed the limited-term positions to reduce the backlog in the numbers of required and random visits it needs to make to meet its statutory requirements.

ALTHOUGH THE DEPARTMENT HAS RECENTLY BEGUN REBUILDING ITS OVERSIGHT OPERATIONS, MUCH MORE REMAINS TO BE DONE

In the spring of 2005, the department's community care licensing division initiated a significant effort to rebuild its operations. This rebuilding effort, which consists of the three phases shown in Figure 2, is intended to increase and improve the department's oversight of its various licensing programs, including its child care program.

FIGURE 2

The Three Phases of the Department's Child Care Oversight Rebuilding Effort



Source: Department of Social Services' community care licensing division.

* Most of the actions in Phase II are dependent on the department receiving the funding proposed in the Governor's Budget for fiscal year 2006–07.

Phase I of the effort focused on rebuilding the "foundation" of the monitoring program. For example, during this initial phase the department planned to increase the number of its periodic inspections to fulfill the 10 percent random visit requirement discussed previously. Additionally, during this phase the department was developing management data through its information systems. The department expects that these data, which will provide information on various items such as visits, citations, and complaints, will be the primary source for management to assess what is occurring in the field. According to the department, until recently such data had to be collected manually from the various regional offices.

Another focus of this initial phase was hiring staff. According to the department, in 2005 it administered its first licensing analyst examination in more than a decade and began hiring from the examination list. As part of this phase, the department also reinstituted the one-week training academy for its analysts. As of March 2006, the department expected to be primarily complete with Phase I by mid-2006.

Phase II of the effort involves increasing monitoring and enforcement activities. Most of this phase is dependent upon the department receiving the increased funding and positions proposed in the fiscal year 2006–07 Governor's Budget discussed previously. For example, if the department receives the proposed funding, it expects to be able to increase the level of random periodic inspections it conducts annually from 10 percent of the licensed facilities to 20 percent[5] and to use temporary positions to catch up on the backlog of visits that has accumulated in recent years.

The department stated that in January 2006 it began electronically collecting data on civil penalties that are assessed by its regional offices.

During this phase the department also expects to expand its electronic management of data. For example, the department stated that in January 2006 it began electronically collecting data on civil penalties that are assessed by its regional offices and will be able to produce management reports containing this information. The department also expects to begin assessing the various management data it began to collect in Phase I for compliance and work productivity. During Phase II, the department further plans to expand the training academy for

[5] State law does not require a 20 percent random sample. However, the department believes such a sample will help it meet the statutory requirement of visiting all facilities at least once every five years. As we discussed previously, the department has yet to start tracking this requirement. Until the department does so, it will not know the optimal percentage of annual random visits.

its analysts to three weeks and add an automation component. According to the department, it held the first session of this expanded training academy in April 2006.

As of March 2006, the department has yet to fully develop plans for Phase III, which it expects to start sometime in 2007. However, at this time the department envisions this phase as a time to analyze the increased information it will have gathered through the greater number of facility visits, better management reports, and other sources such as internal reviews. It then plans to use these sources of information to determine which of its existing policies, processes, and operations warrant follow-up, correction, modification, or additional training. Similarly, during this phase the department anticipates having enough experience with its training academy for analysts to be able to determine whether the content needs to be modified. Further, the department hopes to be able to perform other activities, such as expanding its automation to better carry out certain internal functions, including workload management and scheduling of visits.

Although the department is rebuilding its child care oversight, its plans as yet do not include at least one program element that it reduced in recent years. Specifically, the department currently does not propose to increase the staffing for its child care advocate program. Since the department acknowledges that its child care advocate staff have provided valuable technical assistance and support to licensees, it may want to consider, as part of its rebuilding effort, whether it is satisfying these needs through alternative means or whether it needs to increase its staffing in this area.

A question for the State's decision makers to consider is whether the level of monitoring the department is working toward is sufficient.

Moreover, as the department continues its rebuilding effort, a question for the State's decision makers to consider is whether the level of monitoring that the department is working toward is sufficient. Specifically, the department's current statutory requirement is to visit each child care facility no less than once every five years, a marked departure from its prior statutory requirement to visit centers annually and homes every three years. In addition, the GAO stated in its September 2004 report that national child care organizations recommend that periodic inspections be conducted at least annually.

We asked the department whether it believed that the frequency of site visits currently provided by state law is adequate to protect the health and safety of children in child care facilities. The department responded that the Legislature has debated this

question over the years, and while no definitive answer exists, the current law was passed to provide for the health and safety of children in child care when resources are scarce. However, the department does not currently have an effective method to track data to measure whether the reduced level of visits has adversely affected the health and safety of children in facilities.

The only measure the department points to, which it calls a "trigger," is indicated in state law. The law specifies that if the number of citations issued increases by 10 percent over the previous year, the department is required in the following year to increase the random sample from 10 percent to 20 percent and may request additional resources to do so. The department stated that it has not hit this trigger. However, the number of citations, which understandably is dependent upon the department's monitoring efforts, has not been an effective indicator in recent years, as the department's number of monitoring visits has fluctuated. For example, the department reported that as the number of periodic inspections it made significantly decreased, from 13,669 visits in fiscal year 2002–03 to 4,361 visits in fiscal year 2003–04 (a 68 percent decrease), citations related to those visits similarly declined, from 18,080 to 6,391 (a 65 percent decrease). The department acknowledged that increased monitoring visits will most likely result in an increase in the number of citations. It stated that as it continues to compile and analyze its new management data, a discussion regarding indicators that are more appropriate may be needed.

THE DEPARTMENT USUALLY CONDUCTED COMPLAINT VISITS PROMPTLY BUT COULD MORE FULLY INVESTIGATE SOME COMPLAINTS

When the department does not consistently follow its complaint procedures or does not thoroughly investigate complaints, it is less certain that children are safe from possible dangers.

The department investigates complaints against licensed child care facilities to ensure that these facilities are providing safe and healthy environments for children in their care. As we discussed previously, when the department recognized that it needed to prioritize its activities in response to declining resources, it decided that conducting and completing all complaint investigations in a timely manner was one of its highest priorities. The department has an established process for addressing complaints, and our review of a sample of complaints at four regional offices found that the department usually conducted complaint visits within the established deadlines. However, the department did not always complete investigations of the complaints within deadlines. Further, the department could have taken additional action to resolve

some of the complaint allegations we reviewed that the department found to be inconclusive. When the department does not consistently follow its complaint procedures or does not thoroughly investigate complaints, it is less certain that children are safe from possible dangers, such as mistreatment and unclean facilities.

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

By law, anyone can register a complaint with the department against a licensed child care facility. A complaint is an allegation that a licensing law or regulation is being violated. The department must investigate all complaints it receives that raise reasonable questions about potential violations of licensing laws or regulations and then must make certain that substantiated complaints—those the department can show are valid—are corrected.

The department begins a complaint investigation of a licensed facility by assessing the seriousness of the complaint; identifying which laws and regulations may have been violated; and reviewing the facility's file, which would show previous interactions with facility representatives. An analyst then makes an unannounced visit to the facility. After gathering and evaluating evidence, the department reaches one of the following conclusions about the complaint:

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

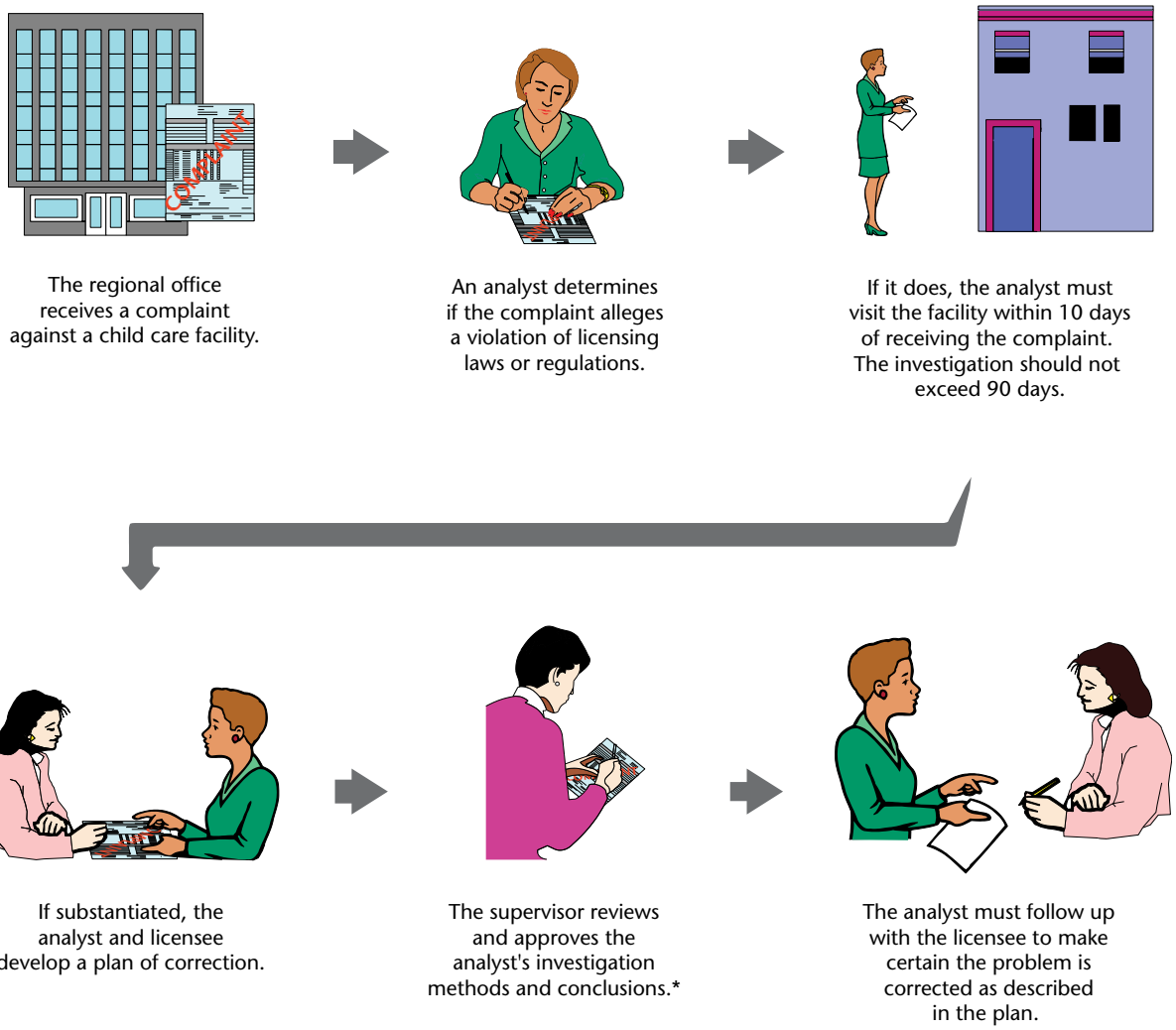
- **Inconclusive:** The alleged action may have happened, but there is not a preponderance of evidence to prove it is valid.

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

If the department substantiates a complaint, it cites the facility for its deficiencies and typically requires the licensee to develop a plan of correction to remedy the problems. Figure 3 on the following page summarizes the department's complaint process.

FIGURE 3

The Department's Complaint Process



* The department implemented a pilot project in 2005 in its six regional child care offices in Southern California for each analyst's supervisor to approve the complaint investigation after the actions described in the plan of correction have taken place.

The Department Usually Conducted Complaint Visits Within Established Deadlines but Did Not Always Complete the Investigations by the Date Required

State law requires the department to conduct an initial visit to a facility within 10 days of receiving a complaint unless the complaint is determined to be without a reasonable basis or there is a valid reason to delay the visit, such as the potential for the visit to interfere with an ongoing police investigation. Our review found that the department conducted 39 of

The department conducted 39 of the 40 complaint visits we reviewed within the required 10 days.

the 40 complaint visits we reviewed within the required 10 days. The department conducted the remaining complaint visit 23 days late.

In addition, the department's evaluator manual states that complaint investigations should not exceed 90 days. According to the department, the investigation is considered complete when a supervisor approves the complaint investigation. In six of the regional offices, a supervisor's approval occurs after an analyst submits the investigation's findings but before corrective action is taken. The remaining six regional offices are currently taking part in a pilot project in which the supervisor's approval occurs after the facility's plan of correction has been completed—that is, after the analyst has verified that the facility has taken the agreed-upon corrective action. However, the department has not yet determined which method of supervisory approval it intends to implement statewide.

Of the 40 complaint investigations we reviewed, the department completed 32 within its 90-day deadline. It completed eight complaint investigations outside the 90-day period, ranging from 39 to 247 days late. The investigation that was completed 247 days late involved allegations that a two-year old was being disciplined improperly. Although it appears that the analyst completed her review promptly, a delay occurred in submitting the complaint report for supervisory review. The analyst does not know why the delay occurred but believes it may have been an oversight.

The Department Could Have Taken Additional Action to Resolve Complaint Allegations It Found to Be Inconclusive

Our review of complaint allegations the department deemed inconclusive revealed that in some instances it could have taken additional action to determine that the allegations were either substantiated or unfounded. The department provides guidance in its evaluator manual regarding the actions its analysts need to take before determining that certain serious allegations, including those involving physical or sexual abuse, are inconclusive. For example, if the supervisor agrees with the analyst's preliminary determination, an attorney in the legal division must be consulted to review the evidence. However, we found little guidance in the manual about actions the department should take before finding that other types of complaint allegations are inconclusive, even though the majority of the complaint allegations we reviewed did

not involve either physical or sexual abuse. In particular, the manual defines an inconclusive allegation but provides no specific guidance to analysts or other staff as to the actions to take before finding that an allegation is inconclusive, including guidance on how to determine whether sufficient evidence has been gathered. According to the department, analysts can consult with their supervisors as well as attorneys in the legal division during complaint investigations. The department also stated that it provides guidance to its child care program staff through training. The training provided to analysts in recent years discussed inconclusive allegations. In addition, the department stated that it held a three-week training academy for child care analysts in April 2006. According to the department, the training was to include exercises designed to help new analysts evaluate evidence and reach conclusions on complaint allegations. Additionally, the department plans to hold an advanced complaint training class that will be provided to all child care licensing staff. The training is to focus on the various activities within the complaint process, including evaluating evidence and determining resolution.

Of the 54 complaint allegations we reviewed that the department found to be inconclusive, we identified 19 for which it could have taken additional action to determine whether the allegation was substantiated or unfounded.

Even with the training, the department needs to ensure that its analysts take all reasonable actions before determining that a complaint allegation is inconclusive. Of the 54 complaint allegations[6] we reviewed that the department had investigated and found to be inconclusive, we identified 19 for which the department could have taken additional action to determine whether the allegation was substantiated or unfounded. For example, we reviewed an allegation that individuals not authorized or employed by a center had direct contact with and were left in charge of nine children. According to the department's files, the analyst interviewed the director and assistant director, who denied the allegation. Six staff members were also interviewed. Three of the six staff members denied the allegation, while the other three stated that a prospective teacher had been left alone with children. The analyst noted that "based on conflicting information, a determination cannot be made" and deemed the allegation to be inconclusive. However, the analyst could have interviewed the children at the center to identify whether any people other than their regular teachers were providing care. Department staff agreed that the additional step of interviewing children could have been taken, depending on the ages of the children involved.

[6] We selected 25 of the 54 inconclusive complaint allegations from our review of 69 complaint allegations. To increase our sample, we additionally selected another 29 inconclusive complaint allegations.

In another example, a complainant alleged that a teacher was observed screaming at a four-year-old child who had attempted to bite another teacher. The analyst interviewed both teachers in October 2005. The teacher who was alleged to be screaming denied the allegation, and the other teacher that was present did not recall whether the first teacher screamed at the child. However, our review of the facility's file showed that the analyst did not make an effort to interview the child because he was not on site at the facility on the date of the visit. The analyst could have requested to interview the child at another time before determining that the allegation was inconclusive. After we discussed the additional action with the analyst in March 2006, his supervisor stated that the analyst would make another visit to the facility to make arrangements to interview the child and other children who may have been present.

According to regional office staff, analysts may not take additional action to resolve complaints they ultimately deem to be inconclusive for a variety of reasons, including time constraints, caseload sizes, and staff vacancies. Regional office staff stated that analysts are expected to complete all complaint investigations within 90 days and to maintain the rest of their caseload, such as conducting prelicensing visits, required visits, and plan of correction visits. Moreover, a staff member from one regional office stated that additional investigative efforts perceived as necessary by one analyst may seem unrealistic to another. Based on experience and instinct, an analyst weighs the likelihood of whether that extra step will produce substantial evidence to influence his or her decision. Nevertheless, supervisors in the regional offices should evaluate for consistency the actions taken among the analysts to ensure that all reasonable actions have been considered before concluding that an allegation is inconclusive. When analysts and supervisors do not ensure that all reasonable actions have been taken, the department may miss opportunities to determine whether complaint allegations are substantiated or unfounded.

A staff member stated that additional investigative efforts perceived as necessary by one analyst may seem unrealistic to another.

THE DEPARTMENT DID NOT ALWAYS DETERMINE THAT FACILITIES CORRECTED IDENTIFIED DEFICIENCIES, AND OFTEN ITS PRESCRIBED CORRECTIVE ACTION WAS NOT VERIFIABLE

During visits to facilities, analysts may issue citations for deficiencies that violate either state laws or department regulations. The department classifies deficiencies into three

The Department Classifies Deficiencies Into Three Types

- **Type A** violations pose a direct and immediate risk to the health, safety, or personal rights of children in care. Examples include missing criminal record clearances for staff, physical abuse, and accessibility of toxic substances to children.
- **Type B** violations have the potential to pose a risk to the health, safety, or personal rights of children in care. Examples include lack of immunization records, overall deterioration of the facility, and lack of menus to verify that dietary needs are met.
- **Type C** violations are technical in nature. Examples include one or two items missing from first aid supplies and menus that are not dated.

types—Types A, B, and C—as shown in the text box. The department's policies call for its analysts to issue citations only for Type A and Type B deficiencies.

Our review of deficiencies cited during complaint, random, and required visits indicated that the department generally categorized deficiencies according to the severity of the risk they posed. However, we found a disparity pertaining to deficiencies cited for absent or expired certifications for first aid and cardiopulmonary resuscitation. Specifically, analysts cited facilities for this deficiency in 15 of the instances we reviewed. In these instances, the department cited the deficiency as a Type A violation eight times, whereas in seven others it cited the deficiency as a Type B violation. In response to our inquiry, the department indicated that these deficiencies are typically considered Type B violations because they present a potential risk if not corrected. Nevertheless, the department's policies do not provide specific guidance as to whether the deficiency is considered either a Type A or Type B violation. Without such guidance, the department may not be treating all facilities consistently.

When the department cites a deficiency, the licensee and department develop and agree upon the corrective action required from the facility, and the department provides the licensee with a report that specifies the deficiency and agreed-upon corrective action, called a plan of correction. Its policy is also to ensure that the facility corrects the deficiency. The department's policies specify different methods its analysts can use to do this. Specifically, an analyst can visit the facility again, hold an informal meeting with the licensee and review the proof of the correction, or verify the corrective action by reviewing information that the facility submits. For example, the analyst can require the facility to submit a photograph showing that it has corrected the deficiency. In addition, the analyst can permit the licensee to certify that a violation has been corrected. However, the department's policies indicate that such certifications may be accepted only when there are no other means to verify that the licensee has corrected the deficiency and should be used only in instances when a facility has a proven record of reliability.

The department's policies generally require a facility that has been cited for a deficiency to correct the problem within 30 days. When an analyst determines that the facility needs more time to correct a deficiency, he or she may extend the deadline for correction. When an extension is granted, the analyst's report should specify actions that must be taken within 30 days to begin correcting the deficiency. However, the analyst's report does not have to specify the actions to be taken to completely correct the deficiency outside the 30-day period. According to the department, many analysts use a control book to ensure timely follow-up on plans of correction.

In Some Instances, the Department Did Not Determine Whether Facilities Corrected the Deficiencies Identified During Its Visits

Our review found that analysts did not always determine whether facilities had corrected the deficiencies arising from complaint, random, and required visits. However, analysts did better at verifying correction of deficiencies found during complaint visits than it did for those found during random and required visits. For the 40 complaint visits we reviewed, the department investigated 69 complaint allegations. The department substantiated 31 of the 69 complaint allegations. Five allegations did not require the licensees to correct the deficiencies because the facilities were no longer operating. For example, one facility was closed shortly after the complaint visit when the licensee was served with a temporary suspension order. Our review found that the department concluded that the facilities had corrected the deficiencies identified for 23 (88 percent) of the remaining 26 substantiated allegations. However, as we discuss in the next section, we found that the agreed-upon corrective action often did not provide methods for the department to verify or measure that deficiencies were corrected.

The department did not ensure that an unlicensed individual had ceased operation by making a follow-up visit until more than four months later, after we inquired about the situation.

In one of the remaining instances in which the department did not determine whether corrective action had been taken, our review found that the department substantiated a complaint that an individual was providing unlicensed care to 18 children. The individual was to submit an application for licensure within 15 days and cease operation until a license was granted. However, when it did not receive an application, the department did not ensure that the individual had ceased operation by making a follow-up visit until more than four months later, after we inquired as to why the file indicated no follow-up by the department.

Of the 23 substantiated allegations with deficiencies the department considered to be corrected, we noted that 20 (87 percent) were corrected within 30 days. For the three remaining allegations, the deficiencies were corrected from 14 to 32 days late. In one instance, the deficiency that was cited related to an individual who had not submitted fingerprints for clearance purposes. A delay occurred when the department informed the licensee that it no longer accepted fingerprint cards and that fingerprints would need to be submitted electronically. The department was implementing a new procedure in response to a law change, which generally required fingerprints to be submitted electronically. In another instance, the department conducted a follow-up visit within 30 days and found that the deficiency continued to exist. When the department made a return visit more than a month later, it learned that the licensee had moved.

For the 40 random and required facility evaluation visits we reviewed, the department concluded that the child care facilities had corrected 95 (75 percent) of the 127 deficiencies for which analysts issued citations. However, similar to our review of complaint-related deficiencies, and as we discuss in the next section, we found instances in which the agreed-upon corrective action was not always verifiable or measurable. For the remaining 32 deficiencies (25 percent), we found no evidence in the facility files that the department had determined whether the deficiencies were corrected. Twenty of these deficiencies involved Type A violations. As we discussed previously, these violations of statutes or regulations pose a direct and immediate risk to the health, safety, and personal rights of children. In one instance in which the department cited a facility for five Type A violations, at the time of our review the department had not determined whether the deficiencies had been corrected for almost five months. In another instance, the department had not determined whether a facility cited for four Type A violations had corrected three of them. According to the department, the facility subsequently closed one year later.

The department cited a facility for five Type A violations, but at the time of our review it had not determined whether the deficiencies had been corrected for almost five months.

The department requires facilities to correct deficiencies within 30 days of being cited unless the analyst determines that more time is needed. For the 95 deficiencies that the department determined had been corrected, 64 (68 percent) were corrected within 30 days. Of the remaining 31 deficiencies, 25 (26 percent) were corrected between 31 and 60 days after the department issued the citations, and six (6 percent) took longer than 60 days

to correct. In none of the 31 instances in which the facility took more than 30 days to correct a deficiency did the analyst indicate that an extension to the time limit was warranted.

The Department Often Cannot Verify or Measure Corrective Action It Requires From Facilities

As we discussed previously, the department concluded for a majority of the deficiencies it cited in complaint, random, and required visits we reviewed that facilities had taken the actions identified and agreed upon in their plans of correction. However, our review identified various instances in which the plan of correction was not written in a way that the department could verify or measure the corrective action the facilities had agreed to take. Thus, it did not always have ongoing assurance that the deficiencies had been corrected.

For instance, the department cited a facility for not keeping an infant under observation at all times, leading to injuries to the infant's head, as well as not informing the infant's parents of the incident. The facility's director at the time stated in the plan of correction that "I have implemented another plan to prevent this from happening again." When we inquired about the specifics of the plan during our review a year after the incident, the department was unable to demonstrate that it ever received such a plan. The department then followed up with the facility and received some written assurances regarding its policies from the facility's current director. However, the department should have written the corrective action in a way that required the facility to submit a plan for its review by a specified date.

In another instance, the department cited a licensee for not being present for at least 80 percent of the hours the facility was in operation, as state regulations require. The plan of correction the department and licensee agreed upon states that the licensee must provide care and supervision at least 80 percent of the time to comply with the regulation. Yet the department neither required the licensee to submit evidence of how she would ensure that she was present during 80 percent of the facility's operating hours nor provided the department with any meaningful assurance that she took the corrective action. When the department does not ensure that it has established plans of correction that can be verified or measured, it cannot be assured that facilities have taken the actions necessary to ensure the health and safety of children in its licensed care facilities.

In some instances, the agreed-upon corrective action was simply a written statement to be submitted to the department that the licensee had taken a particular action.

Additionally, in some instances the agreed-upon corrective action was simply a written statement to be submitted to the department that the licensee had taken a particular action. For example, the department cited a licensee for not ensuring that outdoor play equipment had sufficient sand beneath it to absorb falls and for having on the playground wood pieces with nails protruding. The plan of correction called for the licensee to submit to the department a written statement that the licensee had replenished the sand and removed the wood pieces. If the department did not believe it was necessary to perform a follow-up visit to inspect the corrective action taken, it could at least have required the licensee to submit more convincing evidence, such as photographs of the playground and receipts for the sand. Doing so would be more consistent with its guidance, which calls for it to accept "self-certifications" only when there is no other way to verify that the deficiency was corrected.

OUR REVIEW OF THE COMPLAINT SPECIALIST PILOT PROJECT IN ONE REGIONAL OFFICE RAISES CONCERNS THAT TIMELY AND APPROPRIATE ACTION HAS NOT ALWAYS BEEN TAKEN TO CORRECT VIOLATIONS

In July 2005 the department implemented throughout its community care licensing division a complaint specialist pilot project (project). The intent of the project is to improve the quality and timeliness of complaint investigations and to build a connection between the department's investigators and division staff. The project requires a complaint specialist—an analyst specializing in complaints—and a senior special investigator (investigator) to work in a team environment to assess and investigate the most serious allegations and incidents that occur in facilities. The department's intent is for the investigator and complaint specialist to focus on the work each does best and most efficiently. The project includes a complaint specialist and investigator in each of the 12 regional child care offices and investigators in the department's bureau of investigations. The department plans for the project to end in mid-2007. During our review, the department asserted that the project seemed to be off to a successful start but that it was too early for a formal evaluation of the project.

However, our review of the project in one regional office disclosed several instances in which the department did not ensure that it took timely and appropriate action to enforce serious health and safety violations. We reviewed complaints about seven facilities—comprising 12 substantiated allegations—

that were investigated by the complaint specialist in the regional office. The allegations in the complaints included sexual abuse, lack of supervision, and an individual in a facility without a criminal record clearance. Similar to the findings from our review of complaints, discussed previously, we found that the department made visits to all seven facilities within the required 10 days. However, the department completed investigations for only two of the seven facilities within its established 90-day period, and it completed investigations of the remaining five facilities from 11 to 87 days late. For example, a complaint substantiating an allegation that the licensee's husband hit a child and knocked him into a wall was completed in 139 days (49 days late) because the complaint specialist did not perform a second visit to conduct additional interviews necessary to substantiate the allegation until 125 days after the complaint was received.

The plan of correction for substantiated allegations about the use of drugs and lack of care and supervision required the licensee to cease drinking alcohol and using prescription medication during the facility's hours of operation.

Similar to the findings of our review of complaint, random, and required visits, discussed previously, we found that the plan of correction did not provide ongoing assurance that corrective action had been taken for several of the allegations for which the department cited deficiencies. For example, the plan of correction for substantiated allegations about use of drugs and lack of care and supervision required the licensee to cease drinking alcohol and using prescription medication during the facility's hours of operation. This requirement was a minimal expectation of the action the licensee should take, and it did not provide the department with assurance that the licensee has sufficiently corrected the deficiencies. For example, the plan of correction could have required the licensee to seek counseling, attend training, or demonstrate in some other manner that she had taken action to resolve these concerns.

At the time of our initial review, the department had taken follow-up action for only two of the seven facilities since the complaint investigations were completed. Specifically, the department took disciplinary action by seeking to revoke two of the facilities' licenses. We discuss such disciplinary actions more fully in Chapter 2. For three of the seven facilities, the department took action such as holding noncompliance conferences and making follow-up visits after we began inquiring about its follow-up on the deficiencies cited. As of mid-April 2006, the department had yet to take further action for the remaining two facilities, even though it had completed each of the investigations between two and four months previously. One of the two facilities was the one in

which the department had substantiated allegations about the use of drugs and lack of care and supervision. However, we note that the department performed two additional visits while the investigation was ongoing to check on the licensee. Although the licensee commented that she was no longer caring for children, she expressed interest in doing so. Nevertheless, the department did not visit her again, instead relying on her comment that she would let the department know if she resumed caring for children. When the department does not complete investigations of serious allegations of health and safety violations in a timely way and does not ensure that appropriate corrective action is taken, it cannot ensure that children in the child care facilities it licenses are cared for in healthy and safe environments.

ALTHOUGH THE DEPARTMENT APPROPRIATELY MONITORED COUNTY LICENSING FUNCTIONS, IT HAS YET TO DEVELOP MANAGEMENT INFORMATION TO EFFECTIVELY OVERSEE ACTIVITIES IN ITS REGIONAL OFFICES

The 12 regional offices for the child care program generally carry out the department's oversight of licensed child care facilities. In addition, the department contracts with six counties to license and monitor the homes within their respective boundaries. We found that the department appropriately monitored the activities of the counties with which it contracts. Further, the department has some existing methods and has started to implement others to help it monitor the activities of its regional offices. However, it has yet to develop the automated management information that will allow it to effectively perform this monitoring. Thus, the department has limited assurance that its regional offices are consistently complying with established procedures. Moreover, it is not in an optimal position to recognize trends or other information that may indicate that the department should modify its procedures.

The Department Appropriately Monitored County Licensing Functions

The department appropriately monitored the licensing activities of the counties it contracts with to license and monitor homes. The six counties that perform their own licensing activities are Del Norte, Inyo, Marin, Mendocino, Sacramento, and Tehama. As of February 2006, these counties collectively were responsible for monitoring approximately 3,800 licensed homes.

For the six counties with which it contracts, the department is responsible for monitoring and reviewing each county's activities as they pertain to licensing homes.

As outlined in its agreement with the counties, the department is responsible for monitoring and reviewing each county's activities as they pertain to licensing homes. The department's county liaison commented that she is in frequent contact with county licensing supervisors and analysts regarding policies and procedures and legal questions. In addition, the department's contracts with the counties require the county liaison or other department staff to provide training to county licensing staff.

In our August 2000 report on the department's licensing and monitoring of child care facilities, we noted that the department lacked a schedule for periodically and consistently monitoring the counties' licensing programs. As a result, the department could not ensure that the county programs were operating effectively. In response to our finding, the department instituted in 2000 a biennial review of each contract county's licensing operations. As part of its biennial review process, the department developed a comprehensive review tool to use during its visits to the county licensing offices. The review process consists of visiting each county's licensing office and assessing activities such as processing of license applications, ensuring that criminal history checks are performed, and determining the timeliness of complaint visits and investigations.

We reviewed the department's review tool and its monitoring of three counties. For two of the three counties, the department conducted a comprehensive review of their licensing and monitoring activities. For the remaining county, the department focused its review on complaints and enforcement activities after concerns came to the department's attention between its scheduled comprehensive reviews of the county. The department directed two counties with noted deficiencies to develop corrective action plans. It ensured that the counties established appropriate plans to address the deficiencies. Thus, for all three reviews the department conducted, we found that it appropriately monitored the counties' activities.

The Department Has Yet to Develop Management Information to Effectively Monitor Its Regional Offices

Although its staff communicate within regional offices and with child care program administration, the department does not have sufficient systems and processes in place to maintain a complete and accurate picture of the work done at its regional offices. The department needs to measure the performance of its regional offices to ensure that the amount and quality of work

The department's current monitoring practices and its lack of fully developed management information have hindered the department's ability to obtain a clear measure of the work performed in its regional offices.

being performed meets its standards. However, the department's current monitoring practices and its lack of fully developed management information have hindered the department's ability to obtain a clear measure of the work performed in its regional offices.

Within the regional offices, analysts communicate with their supervisors and the regional manager in the course of their work, as well as with other analysts and supervisors. The department also has a process for providing analysts with supervisory feedback on the quality of their work. In addition, the department implemented in October 2005 a monthly workload review process for its analysts. This process is designed to assist supervisors in monitoring analyst workloads and addressing any problems identified.

The administrator who oversees the child care program (program administrator) communicates with the regional offices through a variety of methods, including conference calls and periodic meetings attended by regional managers. In addition, regional managers communicate with the assistant program administrator to whom they report. The program administrator also gains insight into the work performed at the regional offices through the normal course of her duties. According to the department, the program administrator regularly communicates with assistant program administrators and regional offices regarding various issues such as complaints and disciplinary actions against licensees. She also monitors other items monthly, such as the number of visits.

The department recently began to employ other methods to gain information about the work done in its regional offices. For example, in July and August 2005 the department paired different regional offices to conduct cross-reviews, called peer reviews, of their office practices. The reviewers typically examined six office procedures at each regional office and reported their findings to the assistant program administrator overseeing the regional office. The assistant program administrators subsequently wrote each regional office a summary of its review results, noting any best practices or items needing improvement that the reviewers found in the procedures they examined. They also required the regional offices to take action to address concerns that were identified.

However, these information exchanges do not sufficiently compensate for the absence of formal management information that could be used to monitor regional offices. As we discussed earlier in this chapter, the department has only recently begun to develop management data on various items such as visits, citations, and complaints. The department believes that once it develops the appropriate reports, these data will be the primary source for management to assess what is occurring in the field. For example, the department is not yet using management data to identify historical trends in the numbers of visits made and citations issued by regional offices. In addition, it is not yet conducting comparative analyses of its regional offices to identify any anomalies. Until its management data reporting capabilities progress, the department will be missing out on opportunities to effectively monitor its regional offices and identify practices that should be modified or emulated.

The department also informed us in March 2006 that it hired a program review analyst in January 2006 to review the regional offices, although it had not yet specified when the reviews will begin. In the meantime, the program review analyst is performing other duties, such as researching and evaluating some of the systems used by licensing staff. In addition, the department plans to have the program review analyst evaluate review tools, including those used for county reviews and peer reviews. The department hopes that the program review analyst's work will identify areas of the child care program that need improvement as well as identify best practices that can be used to improve its regional offices.

The information systems that the department currently uses are not optimal for collecting data on the activities performed at its regional offices. The department operates three information systems, which have not been easily linked to one another: a licensing information system that stores data on facilities and the licensees and other individuals who either work or reside there, a field automation system that provides electronic versions of forms that analysts use to document their work, and a legal case tracking system for documenting cases referred for legal action. The data that would be most useful to the department in measuring work activities at its regional offices are contained in the field automation system. However, although this system automates office work and paper processes, it is not designed as a traditional database for data storage, data retrieval, and report creation. Consequently, the department has found it challenging to extract information from it.

The department has found it challenging to extract information from its field automation system that analysts use to document their work.

As part of the department's plan to rebuild its child care oversight, the department has recently purchased middleware[7] to better access the data stored in the field automation system. As of early May 2006, the department stated that it was testing this software. In addition, the department has drafted an information technology strategic plan for the community care licensing division. Once the plan is finalized and approved, the department plans to implement it incrementally within the various phases of its rebuilding effort.

THE DEPARTMENT HAS A PROCESS FOR INFORMING PARENTS OF CERTAIN PROBLEMS AT FACILITIES BUT HAS YET TO MAKE SUCH INFORMATION READILY AVAILABLE TO THE PUBLIC

In accordance with state law, the department has established a process to inform parents of certain deficiencies it has identified at child care facilities. This information is available to parents at specific child care facilities and at the regional offices. However, the information is not yet readily available to the public. State law enacted in 2003 requires certain information about monitoring visits to be posted for 30 days in each facility. Specifically, the department must post the notice that a site visit was conducted. The licensee must also post any report documenting the citation of any Type A deficiency, including complaint investigations with substantiated allegations. In addition, the licensee must post the completed plan of correction. Further, state law requires facilities to keep and make accessible to the public for three years any report pertaining to a facility visit or substantiated complaint.

In addition to the information made available at individual facilities, site visit information is available to the public either by request over the phone or at the regional office that monitors facilities in the area. At the regional office, the public can review all nonconfidential information related to visits performed. For example, the public can review complaints found to be substantiated or inconclusive, complaint and facility visits that resulted in Type A and Type B deficiencies, and criminal record exemptions. However, because obtaining this information requires visiting a facility or making a request to a regional office, the data are not readily available to the public and thus may not be used to the extent possible. The department has

The department has expressed its intent to put all nonconfidential information regarding site visits on its Web site.

[7] Middleware refers to software applications that provide an interface between other software applications.

expressed its intent to put all nonconfidential information regarding site visits on its Web site. As of April 2006, the department stated that it had begun the necessary planning, but that implementation will be dependent on funding.

We reviewed how organizations that oversee child care licensing in various states provide information to the public regarding licensed facilities. Some states provide compliance information for the facilities they license on their Web sites to varying extents. For example, the State of Washington indicates on its Web site whether there is a "licensing concern" with a particular facility. Washington's Web site defines a licensing concern as a situation in which the provider is undergoing an investigation for one or more licensing complaints. However, the Web site does not provide any specific information about the concern and encourages interested parties to call for more information. Texas and Florida provide comprehensive facility inspection histories, allowing users to review the results of facility inspections, including descriptions of violations.

Some states have established voluntary quality rating programs for licensees. For example, North Carolina and Oklahoma assign stars to facilities based on the extent to which they meet or exceed the minimum regulatory requirements such as provider education and compliance history. Florida uses a gold seal quality rating for a similar purpose. By facilitating public access to information regarding the quality of child care provided at licensed facilities, these states may assist consumers in choosing suitable child care and encourage licensees to comply with and surpass minimum licensing requirements.

RECOMMENDATIONS

To ensure that the department continues to make monitoring visits, including periodic inspections and complaint visits, and carries out its other required responsibilities for child care facilities, the department should:

- Develop a plan to measure its random and required visits against its statutory requirement to visit each facility at least once every five years and assess its progress in meeting the requirement. In addition, it should continue to assess its progress in meeting its other statutory visit requirements. Further, it should ensure that the data it uses to assess its progress in meeting the various requirements are sufficiently reliable.

- Continue its efforts to rebuild the oversight operations of its child care program and assess the sufficiency of its current monitoring efforts and statutory requirements to ensure the health and safety of children in child care facilities. As part of its assessment, the department should evaluate whether its caseloads and frequency of periodic inspections are sufficient.

- Complete complaint investigations within the established 90-day period. In addition, the department should revise its policies to identify specific actions its child care program staff could take to reduce the number of inconclusive complaint findings. Further, the department should continue its plans to train all of its analysts in evaluating evidence and reaching conclusions on complaint allegations.

- Evaluate its pilot project for supervisory approval after the plan of correction has been completed and implement a consistent process statewide for ensuring that licensees take appropriate corrective action.

- Provide specific guidance to its staff about whether deficiencies, such as those cited for absent or expired certifications for first aid and cardiopulmonary resuscitation, should be categorized as Type A or Type B violations.

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

- Conduct a review of the complaint specialist pilot project in its regional offices. The review should include, at a minimum, the timeliness and appropriateness of actions taken since the project's implementation. The department should then use the results of its review to determine how it should modify its existing processes.

- Develop sufficient automated management information to facilitate the effective oversight of its child care program regional offices.

- Continue its efforts to make all nonconfidential information about its monitoring visits more readily available to the public. ■

CHAPTER 2

The Department Needs to Improve Its Enforcement Activities to Address Health and Safety Violations by Child Care Facilities

CHAPTER SUMMARY

To address health and safety violations by child care facilities, the Department of Social Services (department) employs a progressive system of enforcement in its child care program regional offices and its legal division. The enforcement measures include assessing civil penalties for violations of state laws and regulations, holding noncompliance conferences after unsuccessfully attempting to gain compliance, and taking legal action, if necessary.

Our review found that the department needs to improve its enforcement activities. In particular, we noted that the department could increase its use of civil penalties as a response to health and safety violations by family child care homes (homes) and child care centers (centers). In addition, we found in several instances we reviewed at four regional offices that the department did not follow its guidance regarding the use of noncompliance conferences to gain compliance from its licensees. In these instances, the department did not conduct the conferences promptly enough, given the severity of the health and safety violations. For example, the department did not require a licensee to attend a noncompliance conference until nearly five months after an incident in which a child was left unattended in the back of a car for two hours.

Although our review of selected cases found that the department appropriately prioritized legal cases and generally ensured that its legal division processed the cases within expected time frames, the regional offices did not always adequately enforce legal actions against licensed child care facilities. For example, we found that the regional offices had not made visits to facilities as required after the facilities' licenses were revoked to ensure that the facilities were no longer operating.

THE DEPARTMENT EMPLOYS A PROGRESSIVE ENFORCEMENT MODEL TO ADDRESS HEALTH AND SAFETY VIOLATIONS

To address health and safety violations by child care facilities, the department uses a progressive system of disciplinary procedures that begins at the regional office level. The department has a number of enforcement options to help bring facilities into compliance. Depending on the seriousness of the violations, one step regional offices may take when a facility has been cited for deficiencies is to increase the frequency of visits to the facility. In certain instances, the regional office is required to levy civil penalties against a facility.

Factors the Department Considers When Determining Actions to Be Taken Against a Noncompliant Facility

- The seriousness of the problem.
- The risk of harm to children in care.
- The length of time the analyst has been working with the licensee to correct the problems.
- The degree of cooperation or ability that the licensee exhibits to come into and remain in full compliance with regulations within a stated time frame.

The department considers various factors (as shown in the text box) when it determines what actions it should take against facilities that do not comply with licensing laws and regulations. Once a licensing program analyst (analyst) has identified a facility as noncompliant, he or she completes a facility compliance plan, unless the problems are serious enough to warrant proceeding to stronger actions. For example, the department's policies call for its analysts to immediately refer to the department's legal division situations involving physical or sexual abuse or ones involving imminent risk to children.

The facility compliance plan formalizes a plan of specific actions for the analyst to use to resolve facility problems with the licensee. The department issues the plan to the licensee at a noncompliance conference, or in some instances at an informal meeting. At the noncompliance conference, the department informs the licensee that unless the deficiencies are corrected and continued compliance is maintained, the facility will be referred for legal action.

After a regional office uses all appropriate enforcement actions available to it and the licensee still fails to comply with laws and regulations, or in instances in which the seriousness of the situation warrants a more immediate response, the department can take legal action against a facility. The types of legal action that can be taken include revoking a facility's license, placing the licensee on probation, and excluding an employee or other individual from a facility. In addition, the department can issue a temporary suspension order (TSO) in conjunction with revoking a facility's license when an immediate health or safety risk exists

and the operation must be closed immediately. If no TSO is issued, the licensee has a legal right to continue to operate while the revocation action proceeds through the legal process.

THE DEPARTMENT COULD INCREASE ITS USE OF CIVIL PENALITIES AS AN ENFORCEMENT TOOL

The regulations for homes prescribe a more limited use of civil penalties for violations than the regulations for centers do.

Our review found that the department could increase its use of civil penalties as a response to health and safety violations by centers and homes. In particular, we found that the department did not assess civil penalties against homes in many instances we reviewed because the regulations for homes prescribe a more limited use of civil penalties for violations than the regulations for centers do. Further, our review of selected centers and homes found that the department did not always assess civil penalties for repeat violations, even though laws and regulations require it. Moreover, we found several instances in which the department might have assessed civil penalties but did not because it did not make follow-up visits to determine whether the facilities corrected deficiencies.

State law and regulations require the department to assess civil penalties against centers and homes for certain violations, including failing to obtain criminal record clearances and operating an unlicensed facility. Consistent with state law, regulations require the department to assess civil penalties against centers and homes for repeat violations. We attempted to obtain a comprehensive view of the extent to which the department levied penalties against homes and centers but were unable to do so because the department has not electronically summarized these data in the past. As we discussed in Chapter 1, the department plans to improve its management information on civil penalties as part of Phase II of its rebuilding efforts. Thus, we focused our review of civil penalties on a sample of 36 centers and 44 homes.

We reviewed 44 homes for deficiencies cited and to see whether the department had assessed civil penalties. Our review identified 24 instances at 12 homes in our sample in which the department cited the homes for repeat violations of the same regulation. It did not assess civil penalties in these instances because the regulations for homes establish civil penalty assessments only for a limited number of specific violations. For example, the regulations for homes specify that civil penalties are to be assessed only for repeat violations of certain regulations, such as failing to inform parents upon request of

the name of any adult affiliated with the home who has been granted a criminal record exemption and failing to post the notification of parents' rights poster in the home. In contrast, typically the regulations for centers do not specifically identify the types of repeat violations to which civil penalty assessments apply. When we questioned the department about the regulations for assessing civil penalties against homes, it pointed to legislative intent as expressed in statute that the program operated by the State for homes should be cost-effective, streamlined, and simple to administer in order to ensure adequate care for children placed in homes, while not placing an undue burden on the providers.

In 11 of the 31 instances we reviewed involving centers, the department did not assess civil penalties for repeat violations of the same regulation within a 12-month period.

In addition, we found that the department did not assess civil penalties in all instances in which state laws and regulations require it. Specifically, in 11 of the 31 instances we reviewed involving centers, the department did not assess civil penalties for repeat violations of the same regulation within a 12-month period. We also found that the department did not assess civil penalties for two of the 17 instances we reviewed in which the department cited homes for criminal record clearance violations. However, the department cited centers for criminal record clearance violations in all 12 of the instances we reviewed for which it was required.

State regulations require that, after the department cites a center for deficiencies, it must conduct a follow-up visit within 10 working days following the date specified for corrections to be made. The regulations further state that no penalty shall be assessed unless a follow-up visit is conducted. The department's evaluator manual states that "if a follow-up visit is not conducted within ten working days of the plan of correction date a civil penalty **cannot** be assessed." However, the department is not precluded from conducting subsequent visits to previously cited facilities. If the department finds that deficiencies remain uncorrected, it can cite the facilities for repeat violations of the same regulation within a 12-month period. Our review of 36 centers disclosed eight instances at four centers in which the department might have assessed civil penalties if it had made any follow-up visits to determine whether facilities corrected deficiencies that were previously cited. We focused our review on centers because of the limited extent to which civil penalties would apply to homes, as we discussed previously.

We also noted that the requirement that ties the department's ability to levy civil penalties to whether it conducts follow-up visits appears inconsistent with direction elsewhere in the manual, which states that such visits are necessary only under certain circumstances, including if correction cannot be verified in any other way. The manual states that the department can verify correction through other means than a visit, such as having the licensee submit a photograph or a copy of a document. In light of other regulations and policies the department uses to assess civil penalties, including its ability to assess for repeat violations, we question the usefulness of the requirement specifying a 10-day follow-up visit before assessing civil penalties.

The department's current approach to civil penalties for homes merits further consideration.

Civil penalties are one more tool that the department could use in its overall enforcement approach. If the department assessed civil penalties more often, it might help avoid the need for stronger enforcement measures if problems continue to occur. In addition, although we recognize that the department wants to ensure that it is not placing an undue burden on homes, we believe that the department's current approach to civil penalties for homes merits further consideration. In response to our question about whether the department has any plans to seek changes to the regulations to address the disparity in civil penalty assessments between centers and homes, the department stated that "this is one of many issues the department is reviewing as part of our rebuilding plan."

THE DEPARTMENT HAS NOT CONSISTENTLY FOLLOWED ITS GUIDANCE ABOUT USING NONCOMPLIANCE CONFERENCES

Our review of a sample of child care facilities at four regional offices revealed that in several instances the department did not follow its guidance about the use of noncompliance conferences to gain compliance from its licensees. In addition, we found that the department did not always conduct the noncompliance conferences promptly, given the severity of the noncompliance. The department's policies call for it to hold a noncompliance conference after it has made unsuccessful attempts to require a child care facility to correct its violations but before it seeks legal action against the facility. Additionally, the department may hold a noncompliance conference after a single incident if it deems it to be appropriate. At a noncompliance conference, child care regional office staff—including the manager—meet with the licensee to discuss the areas of noncompliance and

the actions the licensee will be required to take, and to inform the licensee that the case will be referred for legal action if the deficiencies are not corrected.

The department's evaluator manual provides general guidance regarding the need for noncompliance conferences and states that if staff have any questions concerning the need for a noncompliance conference rather than going directly to a legal action, they should consult the legal division. However, the manual does not provide specific guidance about the types and severity of noncompliance that may result in a conference.

To provide such guidance, the department's former deputy director of the community care licensing division described, in a memorandum dated May 3, 2004, certain key areas of noncompliance "that have the greatest potential for serious harm." According to this memorandum, these areas include accessibility of swimming pools and bodies of water, children left unattended in cars, clients[8] left unsupervised or leaving a facility without staff knowledge, and the failure of a facility employee or adult resident to obtain a criminal record clearance. In addition, the memorandum described a standard approach that staff should take to address deficiencies in these and other areas involving a direct threat to the health and safety of clients. For example, the memorandum stated that the licensee should be required to attend a noncompliance conference if a violation is not serious enough to warrant immediate legal action but would have harmful consequences if it were repeated. Additionally, when a noncompliance conference is held, staff are to identify the facility as needing a required annual visit for at least two years. The memorandum further stated that if a second deficiency in the same critical area is cited at any visit, regardless of the nature of the deficiency, legal action should always be pursued, unless community care licensing division management approves the decision not to pursue such action.

Contrary to a May 2004 memorandum's requirements, the department did not require noncompliance conferences to be held after the initial citation for seven of 12 facilities we reviewed.

Our review of 18 child care facilities found 12 facilities in which the department issued citations after the May 2004 memorandum for areas that the memorandum identified as key. Contrary to the memorandum's requirements, the department did not require noncompliance conferences to be held after the initial citation for seven of these facilities. For example, the department cited a facility on May 12, 2004, for not having a criminal record clearance for an employee. Yet the department

[8] The memorandum was directed to all licensing programs in the community care licensing division. Its clients include children and adults, including the elderly.

did not require the licensee to attend a noncompliance conference until February 2005, nearly nine months later, after it made a visit in early November 2004 and again cited the facility for failing to ensure that all employees had criminal record clearances.[9] In fact, of the 12 facilities, five received at least one citation for failure to obtain criminal record clearances. However, four of the five facilities were not required to attend a noncompliance conference until after the department cited them for additional violations during subsequent visits.

One regional manager we spoke with stated that noncompliance conferences are generally held after the second criminal record clearance violation. Another regional manager indicated that it is impractical to hold a noncompliance conference for every single violation of a criminal record clearance violation and said that each case must be treated individually. If the department does not believe it is practical or necessary for noncompliance conferences to be held after initial criminal record clearance violations, it should modify the guidance provided in its May 2004 memorandum, which directed staff to do so.

If the department identifies a criminal record clearance violation, it is important to take additional steps to determine the reason an individual is not cleared.

Further, if the department identifies a criminal record clearance violation, it is important for it to take additional steps to determine the reason an individual is not cleared. For example, in one case that we looked at, a regional office cited a licensee in March 2004 for allowing an individual to be present at the facility without a criminal record clearance. During the visit, the licensee informed the regional office that the individual was on parole and that he worked for her. Three months later, the regional office made another visit to the facility and cited the licensee for allowing the same individual to be present at the facility without a criminal record clearance and assessed a civil penalty. A week later the regional office returned to the facility and again observed the uncleared individual present at the facility, cited the licensee again, and assessed a second civil penalty. After the third violation, the regional office discovered that the individual was a second-strike felon on parole after serving a nine-year prison sentence for robbery, at which point the regional office took action to have the individual immediately excluded from the facility. However, we question why the department did not attempt to determine what the nature of the individual's offense was after the first visit, when it was informed that the individual was on parole.

[9] The department performed a follow-up visit in late June 2004 and was informed that the employee who was noted as not having a clearance at the May 2004 visit no longer worked at the facility. The citation in November 2004 related to a lack of criminal record clearances for other individuals.

In another example, the department cited a facility for lack of supervision after a toddler was picked up from the facility by another child's grandfather without the parent's knowledge. The department cited the same facility nearly six months later for leaving a child alone. It cited the facility a third time more than four months later when a child left his classroom and was found in another building. Finally, about a month after this third incident, the department held a noncompliance conference with facility representatives. Although we recognize that the first citation occurred several months before the May 2004 memorandum was circulated, the second citation occurred a few months after it and should have prompted a noncompliance conference.

We also found instances in which the department's regional offices were inconsistent about the timing of noncompliance conferences. For example, one regional office required a licensee to attend a noncompliance conference after it was notified that the facility had allowed a special needs child attending a child care facility located at a church to wander off alone into a baptismal pool. The noncompliance conference was held with the licensee 23 days after the incident. In contrast, another regional office did not require a licensee to attend a noncompliance conference until nearly five months after an incident in which a child was left unattended in the back of a car for two hours. The regional manager acknowledged that the delay was the department's fault and indicated that it occurred in part because of an oversight that took place when an analyst went on extended leave. We did note that the department was informed that the employee who left the child in the back of the car was terminated the day after the incident.

One regional office did not require a licensee to attend a noncompliance conference until nearly five months after an incident in which a child was left unattended in the back of a car for two hours.

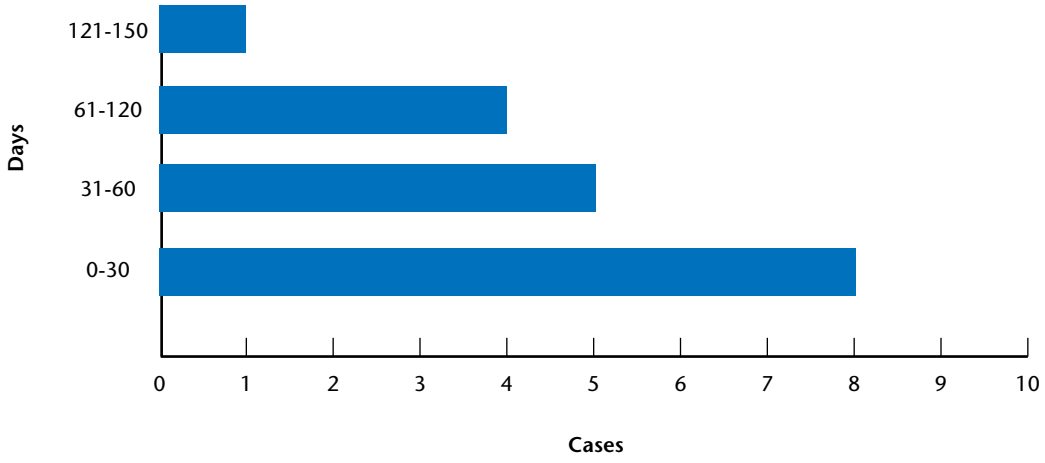
The department has not specified a time frame for holding a noncompliance conference, but the four regional office managers with whom we discussed the matter generally indicated that the severity of the violation dictated the timing of the conference. One manager stated that for more serious issues, the department tries to bring a licensee in for a conference within a week, and for less serious issues within a month. Another manager stated that the department attempts to hold conferences within two weeks for serious incidents and if the problems are less serious, then "we could wait a bit." A third manager tries to hold noncompliance conferences within a month of staff preparing the facility compliance plan but, depending upon the nature of the violation, may hold it as soon as possible. Some managers mentioned that scheduling conflicts can create delays. In fact, one manager stated that the

"the most realistic goal is to get the licensees in as soon as is practical given all of the other demands placed on my time and assuming an appropriate citation has already been made." The manager further commented that given the time available, this can sometimes be three or four weeks or "maybe more."

Our review of 18 facilities in which the department held noncompliance conferences found that eight were held within 30 days of the most recent violation, as shown in Figure 4. For five of the 18 facilities we reviewed, the department conducted a noncompliance conference between one and two months after the facility's last violation. For the remaining five facilities, the department took between two and five months to hold a noncompliance conference. When the department does not hold noncompliance conferences promptly, it increases the risk that unsafe or undesirable conditions will be allowed to continue.

FIGURE 4

Number of Days the Department Took to Hold a Noncompliance Conference for the 18 Facilities We Reviewed



Source: Bureau of State Audits' analysis.

REGIONAL OFFICES MAY NOT ALWAYS CONSULT LEGAL STAFF AS EARLY AS POSSIBLE

The department's evaluator manual provides general guidance as to when regional offices should seek to revoke a facility's license. For example, the manual states that regional offices may choose to recommend that a provider's license be revoked when the provider commits serious violations of regulations, engages in

criminal conduct, or repeatedly violates licensing regulations despite multiple citations, plans of corrections, civil penalties, informal meetings, and noncompliance conferences. Further, the evaluator manual provides some guidance as to whether staff should seek to have the facility immediately closed through a TSO while they pursue action to revoke the license. For example, the evaluator manual states that a TSO may be warranted under specified circumstances, such as when a licensee or other person in a facility has engaged in physical or sexual abuse of clients or has so poorly supervised clients that there is substantial risk to their health, welfare, or safety.

The department's evaluator manual also states that there are no hard and fast rules as to what action is appropriate in a given case, and that it is important to assess each case independently. As would be expected in such circumstances, the manual calls for the department's legal division to play a role in the process. For example, the manual states that situations involving physical or sexual abuse or ones in which there is imminent risk to children should be referred immediately to the legal division. Further, it states that regional offices should consult with their legal consultants in cases in which the regional office is unsure as to whether legal action is warranted.

We question whether regional offices are consulting the legal division as early in the process as would be beneficial.

We noted some cases that caused us to question whether regional offices are consulting the legal division as early in the process as would be beneficial. For example, in one case the regional office received a complaint from a local police department on January 9, 2004, that a child care provider's husband was arrested for illegally discharging a firearm while intoxicated outside the child care home after a lengthy stand-off with the police. The arrest occurred outside the home's hours of operation. Although the regional office had sufficient information to at least be concerned that an imminent risk to children could exist, it did not consult the legal division at that time and instead proceeded to investigate the complaint on its own. More than a month later, after completing the investigation, the regional office consulted with the legal division and determined that a TSO action was warranted. As we discussed previously, a TSO is issued when an immediate health or safety risk exists and the operation must be closed immediately. However, according to the regional manager, the TSO was rejected by the attorney general's office because of the delay between the date the complaint was received and the date the TSO was requested. The regional manager further commented that the attorney general's office also believed

that a noncompliance conference the regional office held gave the impression that the regional office was trying to work with the licensee to resolve the complaint, which raised legal issues. In fact, the regional office had held the noncompliance conference to alert the licensee to the issues, expecting the licensee to forfeit the facility's license, but that did not occur.

Because the TSO was rejected, the department was forced to proceed with only a revocation action, which allows a facility to continue operating until the revocation becomes effective. In this case, the regional manager stated that the licensee informed the office in late February 2004 that she was not currently operating. However, she could have chosen to continue operating the facility, with her husband present, until mid-October 2004, when the revocation action against her became effective. Further, we noted that the regional office never followed up to verify that she was no longer operating.

In another example, a regional office held a noncompliance conference with a licensee in May 2003, after the facility was cited for three separate incidents involving failure to supervise children in its care. Following the noncompliance conference, the regional office cited the facility again in September 2003 for lack of supervision for an incident that occurred in July 2003 when a child who is normally picked up at the center was incorrectly placed on a bus. In March 2004, the facility received a citation for violating a child's personal rights when a staff member picked a sleeping child up by the child's arm and opposite leg and placed the child on the bare floor. Four months later, the facility was cited twice more for failing to adequately supervise children in its care. In one incident, a child was placed on the wrong bus. In the second incident, a child was lost at the facility and was found alone in the courtyard by a clerk. Finally, within a few months after these last two incidents, the regional office referred the facility to the legal division for a revocation action, and ultimately the facility was put on probation. However, we question whether it would not have been beneficial for the regional office to consult with the legal division earlier to help determine whether it was following the appropriate course of action.

In January 2006, the department implemented a pilot project in Southern California in an effort to provide more immediate access to legal consultants.

The department acknowledges the need to use legal consultants more effectively. In January 2006, the department implemented a pilot project in Southern California in an effort to provide licensing and investigative staff with more immediate access to legal consultants and give greater consistency in the legal

consultation services and advice given. The goal is to enable licensing staff to more readily assess situations, identify options and appropriate actions to take, and respond more effectively to issues that confront them. The project is scheduled to be complete by mid-2007.

THE DEPARTMENT APPROPRIATELY PRIORITIZED LEGAL CASES WE REVIEWED AND GENERALLY ENSURED THAT THEY WERE PROCESSED WITHIN EXPECTED TIME FRAMES

Through its legal division, the department can take formal legal disciplinary action against a licensee, employee, or other individual who repeatedly fails to comply with or commits a serious violation of licensing laws or regulations or engages in criminal conduct. The department's options are to suspend or revoke the facility's license, exclude an employee or other individual from a facility, or place the licensee on probation. When an immediate health or safety hazard exists that warrants immediate closure, the department can issue a TSO in conjunction with revoking the license.

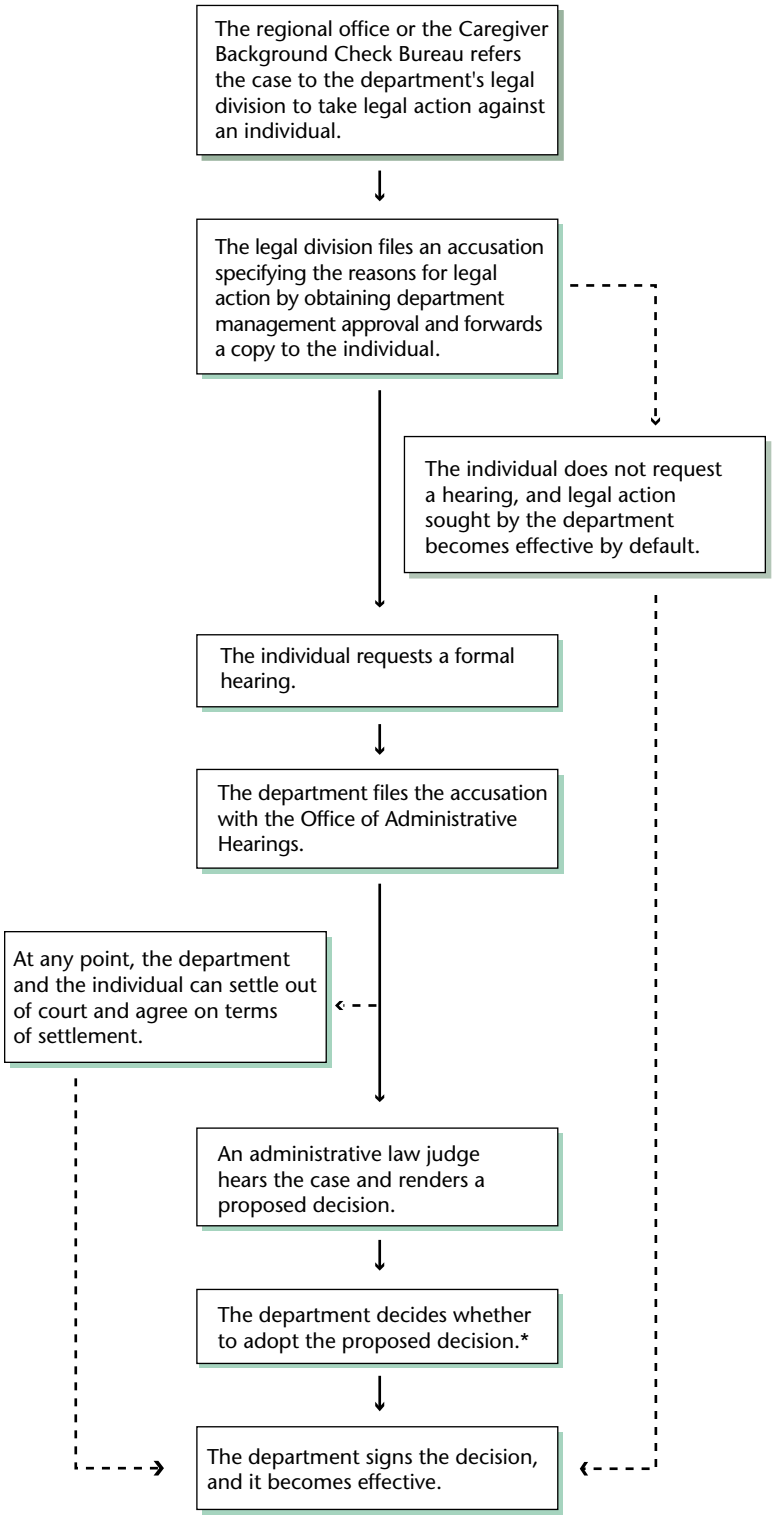
As Figure 5 illustrates, the department's process of taking legal action against a facility is initiated by a regional office or the Caregiver Background Check Bureau. It may involve either an administrative law judge deciding the case or the department and the licensee negotiating a settlement. Once the department's legal division receives a request for legal action, it prepares a legal document, known as an accusation, specifying the department's reasons for taking legal action. After the department's attorney assigned to the case circulates the accusation, the deputy director for the community care licensing division (deputy director) approves and signs it.

The department has an internal goal of six months for serving an accusation once the case is received in the legal division; a priority system is intended to ensure that the more serious cases are handled more quickly.

After the deputy director signs the accusation, the department serves it to the individual. The department has an internal goal of six months for serving the accusation once the case is received in the legal division; a priority system is intended to ensure that the more serious cases are handled more quickly. Once served, the individual has a specified amount of time to request a formal hearing. If the individual does not request a formal hearing, the legal action sought by the department becomes effective by default. If the individual requests a hearing, the department files the accusation with the Office of Administrative Hearings and schedules a hearing date. At the hearing, an administrative law judge hears the case and issues

FIGURE 5

The Department's Legal Action Process



* If the department rejects the proposed decision, an attorney not previously involved in the case reviews the record of the hearing. The attorney then writes and recommends an alternate decision. The department comments that this rarely happens.

a proposed decision. The department then decides whether to adopt the decision or, in rare cases, to reject it and allow an attorney not previously involved in the case to recommend an alternate decision. At any point in this process, the department and individual can reach a settlement out of court.

Our review found that the department appropriately prioritized legal cases and, in general, ensured that its legal division processed the cases within expected time frames. Attorneys in the legal division are responsible for prioritizing the cases they receive based on the information the regional offices provide. The department gives its attorneys written guidance instructing them on the department's case filing priorities. For instance, the department places the highest priority on cases in which it issues a TSO against a facility. In contrast, the department places a lower priority on cases that pose less risk to the clients. For example, the department places its next-to-lowest priority on cases in which the department is seeking revocation "for the record" because the facility is not operating and the reasons for revocation are less serious than physical or sexual abuse or other potentially harmful conduct.

Our review indicated that the legal division followed its priority system and met its six-month goal for 18 of the 20 cases we reviewed.

Our review of 20 legal cases indicated that the legal division followed its priority system and met its six-month goal for 18 of the 20 cases. For example, in one case a licensee was accused of threatening a parent with a knife during an altercation, and the department served the accusation within four days. For two of the 20 cases, the department did not meet its six-month goal. In one case that took about seven and a half months to serve, the department indicated that it had been on track to meet the goal but then chose to modify the accusation to include a recent violation by the licensee. For a second case that took about eight months to serve, the department stated that the legal division was processing an abnormally large number of cases at the time. Because the department believed that the licensee in the case did not pose a serious or immediate threat to children, the department stated that it processed higher-priority cases ahead of it.

In addition, we found that six of the 20 cases were serious allegations in which the department issued TSOs. For all six cases, the department served the accusation within six days. Further, we found that an additional six of the 20 cases we reviewed were "expedited revocation" cases in which the department determined that the allegations did not constitute

an immediate health or safety risk but were serious enough to warrant quick action. For these six cases, the department served the accusation within two to 110 days.

THE DEPARTMENT'S ENFORCEMENT OF LEGAL ACTIONS CONTINUES TO NEED IMPROVEMENT

Once the department signs a legal decision to revoke a child care provider's license, exclude an individual from a facility, or place a provider on probation, the regional office is responsible for enforcing the legal action. We reviewed files for 28 legal cases—15 in which the facility's license was revoked and another 13 that involved facilities placed on probation—and found that the regional offices did not always adequately enforce legal actions against licensed child care facilities. In our August 2000 audit report, we indicated that the department did not effectively ensure that all licensees placed on probation were complying with their probation terms and that it did not diligently enforce revocation and exclusion decisions. Although the department distributed revised policies and procedures for enforcing legal decisions in 2001, we found in our August 2003 audit that it did not always adhere to these policies and procedures.

As of March 2006, the department had not made visits to 12 of 15 facilities that had their licenses revoked, although it had been longer than 90 days in each instance.

When the department revokes a facility's license, it requires the applicable regional office to visit the facility at least once within 90 days after the effective date of the legal decision, unless it knows that the facility is not operating. From our review of 15 revocation cases, we found that as of March 2006 the department had not made visits to 12 of the facilities, although it had been longer than 90 days in each instance. For one of the three remaining facilities, we could not verify whether the department had visited the facility. Although the regional office subsequently provided us with a handwritten report of the visit after we noted that the regional office's file on the facility did not contain documentation that a visit was performed, the report was not entered into the department's database system, as is standard procedure. According to the regional manager, the analyst was unaware that visit reports for closed facilities could be entered into the database system.

For five of the 12 facilities the department did not visit, the department had issued a TSO in addition to initiating the revocation action. Because a TSO is intended to close a facility before the department adopts a legal decision, the department's evaluator manual does not require regional offices to make visits

to the facility after the effective revocation date. We asked the department how it ensures that facilities are not continuing to operate after it issues a TSO. The department pointed to another section of its manual, which requires follow-up visits as necessary after a TSO is issued to ensure that the facility has ceased operation. In addition, the department indicated that it provides information about the TSO to others, including parents. Further, the department noted that state law imposes a $500 fine for removing the posted notice indicating the facility is closed and makes it a misdemeanor to continue operating after a TSO is issued. Nevertheless, the department did not conduct follow-up visits in the five instances we noted. Because the department did not perform follow-up visits to the five facilities, it did not know whether the facilities had complied with the TSOs.

Two regional managers we spoke with believe it is difficult for facilities to operate without the department's knowledge once a TSO has been issued. One regional manager stated that too many people, including the department, parents, neighbors, the local resource and referral agency, child-care subsidy agencies, and the police, are aware that the facility is supposed to be closed. In addition, the regional manager stated that often an analyst will drive by to ensure that the mandatory "Closed for Business" sign is in place. Nevertheless, in the instances we reviewed, the department's files did not indicate that staff had obtained any assurance that the facilities had complied with the TSOs and that a follow-up visit was not necessary.

For the seven facilities that were not visited and did not receive a TSO, we found documentation for only four showing that the facility was no longer operating.

For the seven facilities that were not visited and did not receive a TSO, we found documentation for only four showing that the facility was no longer operating. Because the department does not require follow-up on revocation cases in which they know the facilities are not operating, it is critical for the regional office to document how they determine that the facilities are no longer operating and therefore require no additional follow-up.

In addition, we found from our review of 13 facilities placed on probation that the department did not make follow-up visits to two of the facilities. As of March 2006, one facility had gone more than two years without a visit since its effective probation date. According to the department, the facility went on inactive status in January 2005, but the department now plans to conduct a visit. Another facility had not been visited in more than 13 months. When the department places a facility on probation, its policy requires the regional office

to visit the facility within 90 days of the effective date of the legal decision. Of the 11 facilities that received visits after their effective probation date, three were not visited within the required 90 days. One of the three facilities received a visit 189 days after the probation date and a second one was visited 171 days after the probation date. For the third facility, the visit missed the 90-day requirement by only three days.

In addition to visiting facilities on probation within 90 days, the department is required to ensure that facilities placed on probation comply with the specific conditions set forth in their probation agreement. In some instances, the department can ensure that a facility is complying with the conditions of probation without making a visit. For example, one probation requirement called for the licensee to complete an anger management program by a specified date. The department required the licensee to submit proof of course completion. Our review of 12 conditions of probation for eight facilities found that regional offices determined whether the facilities complied with 11 of the conditions. However, in one case the regional office did not verify that the licensee attended a training class on the laws and regulations governing family child care homes.

In one case we reviewed, the regional office did not conduct a visit to verify that the licensee was complying with the exclusion order until nearly a year after the order became effective.

Three cases we reviewed that required license revocation also required the department to exclude employees or adult residents from the facilities. When an individual has been excluded, the regional office is required to verify at the next evaluation visit that the licensee is complying with the exclusion order. For one of the three cases we reviewed, the regional office did not conduct a visit until nearly a year after the exclusion order became effective. In the second case, the department found that the licensee had not complied with the exclusion order when the regional office substantiated a complaint from a former employee that an excluded employee and her husband, who had not submitted fingerprints, were present at the facility on various occasions. The employee had been ordered excluded more than a month prior to the complaint, and her husband, a convicted felon for whom a criminal record exemption had not been sought, was never supposed to be allowed at the facility. Despite these circumstances, the department did not make any more visits to the facility for the remaining 11 months that the facility continued to operate.

For the third case, the department issued an immediate exclusion order against an individual in early July 2004. At the time of the facility's closure in October 2004, the department

had not visited the facility to ensure that the licensee was complying with the exclusion order. However, due to repeat violations cited against the licensee for the individual being present at the facility, the seriousness of the crimes committed by the individual for whom the exclusion order was issued, and the fact that the regional office had reason to believe that the individual was married to the licensee, we question why the department did not conduct a visit of the facility to ensure that the licensee was complying with the order.

The department's follow-up requirements for exclusion actions differ from its follow-up requirements for revocation and probation actions, which appears to have contributed to the situations we noted in which visits were not conducted promptly. As opposed to probation and revocation cases, which require regional offices to visit the facility within 90 days of the order, for exclusion cases the evaluator manual states that regional offices must verify at the next evaluation visit that the licensee is complying with the exclusion order. As we discussed in Chapter 1, state law requires the department to conduct annual visits when it must verify that a person ordered out of a facility is no longer at the facility, among other circumstances. However, because regional offices may take up to a year to make an evaluation visit to a facility, a licensee who is not complying with the exclusion order may allow the excluded individual to be present at the facility during this time.

Further, state law requires that licensees notify parents when someone has been excluded from a home. Thus, for homes, the manual includes an additional requirement that regional offices must verify at the next facility evaluation visit that the licensee has notified all parents that the individual has been excluded. Once again, however, because the regional office may take up to a year to visit the facility, the department may not know during that time whether parents have been made aware that an individual was excluded. According to the department, a visit will be made soon after it issues an exclusion order if it has reason to believe that the individual is still present in a facility.

Having a policy that may allow an excluded individual to continue to be present in a facility for up to a year without being detected places children at unnecessary risk.

We believe that the department needs to revise its current approach to following up on exclusion orders. Having a policy that may allow an excluded individual to continue to be present in a facility for up to a year without being detected places children at unnecessary risk. Further, although we acknowledge

that the department may visit sooner, it bases its decision to do so on information that comes to its attention, an approach that is reactive rather than proactive.

RECOMMENDATIONS

To improve its enforcement actions in order to effectively address health and safety violations by child care facilities, the department should:

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

- Clarify its direction to regional office staff to help ensure that they are using noncompliance conferences promptly and in appropriate instances. Additionally, the department should reevaluate the May 3, 2004, memorandum and, to the extent that it reflects the department's current intent, incorporate the guidance into its evaluator manual. Further, the department should periodically review regional offices' use of noncompliance conferences to ensure that they are consistently following established policies.

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

- Require follow-up monitoring visits to ensure that child care facilities with revoked licenses are not operating and that individuals excluded from facilities are not present in the facilities. The department should also revise its policies for following up on excluded individuals to ensure that it more promptly verifies that they are not present in facilities.

- Ensure that visits to facilities on probation are made within the required deadline.

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

Respectfully submitted,

ELAINE M. HOWLE
State Auditor

Date: May 25, 2006

Staff: Karen L. McKenna, CPA, Audit Principal
Russ Hayden, CGFM
Natalya Fedorova
Ralph Flynn
Erik Stokes
Toufic Tabshouri

Agency's comments provided as text only.

Department of Social Services
744 P Street
Sacramento, CA 95814

May 12, 2006

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

Dear Ms. Howle,

Attached is the response provided by the California Department of Social Services to the audit of the Community Care Licensing (CCL) Child Care Program, entitled "In Rebuilding its Child Care Program Oversight, the Department Needs to Improve its Monitoring Efforts and Enforcement Actions." We share the Legislature's commitment to ensuring the health and safety of children in licensed child care facilities. In tandem with the implementation of many new improvements and efficiencies in the CCL Program, we welcome the audit results as important contributions to our enforcement policies that will help increase protections for children throughout the state.

Child safety is one of the highest priorities of Governor Schwarzenegger, as evidenced by the considerable resources dedicated to the CCL Program over the past year and a half. This Administration has been actively engaged in rebuilding and making continuous improvements to this important program. We have invested substantial general fund money and management time and are beginning to see positive results:

- Immediately responding to complaints remains a top priority. CCL is responding to complaints within the required ten-day response period 98 percent of the time.

- Since January 2005 when the hiring freeze was lifted, more than 180 employees have been hired; 114 of these employees are devoted to monitoring licensed facilities, and the CCL vacancy rate is currently under seven percent. In the previous two years, the vacancy rate ranged from 10-14 percent.

- Last year, approximately 82 percent of the required visits were made, which included a ten percent random sample. This year, CCL is projecting to exceed 100 percent of the aforementioned requirement, and the Governor has requested 67 additional positions to help meet the additional mandate of visiting each facility no less than once every five years.

- Last year, approximately 74,000 visits were made to CCL facilities, and approximately 88,000 visits this fiscal year are projected – a 20 percent increase.

- The training Academy for the new monitoring and enforcement staff has been reinstituted. The Governor has included funds in his proposed 2006-07 budget for an expanded and updated version of the Academy, which will include training on the new automated reporting system and a more extensive component on complaint investigations.

- Critical software has been purchased to implement automation efficiencies that will reduce the duplicate entry of information and communicate timely licensing and enforcement finding to other governmental agencies. Other automation improvements are planned for the near future.

- Future enhancements to the CCL website are underway to provide the public with important information regarding facility compliance in a more user friendly manner.

CCL has the challenging job of licensing and providing oversight of more than 88,000 community care facilities with a capacity of 1.5 million people. The child care component alone represents 60,000 facilities with a capacity of 1.1 million children. We depend on our many community partners, parents, and others to provide us with valuable information and feedback to inform our improvements. We view the recommendations in your report as contributing to this important effort.

Thank you for acknowledging the improvements we have already begun and for the additional recommendations, which we will seriously consider as we continue with our rebuilding efforts.

Sincerely,

(Signed by: Cliff Allenby)

CLIFF ALLENBY
Interim Director

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES
RESPONSES TO THE BUREAU OF STATE AUDITS RECOMMENDATIONS
2006

INTRODUCTION

Child safety is one of Governor Schwarzenegger's highest priorities, as evidenced by the considerable resources dedicated to the Community Care Licensing Division (CCLD) of the California Department of Social Services (CDSS) over the past year and a half. This Administration has been actively engaged in rebuilding and making continuous improvements to this important program. We have invested substantial resources and management time and are beginning to see positive results:

- Immediately responding to complaints remains a top priority. Community Care Licensing (CCL) Program is responding to complaints within the required ten-day response period 98 percent of the time.

- Since January 2005 when the hiring freeze was lifted, more than 180 employees have been hired; 114 of these employees are devoted to licensing and monitoring facilities, and the CCLD vacancy rate is currently under seven percent. In the previous two years, the vacancy rate ranged from 10 -14 percent.

- Last year, approximately 82 percent of the required visits were made, which included a 10 percent random sample. This year, CCLD is projecting to exceed 10 percent of the aforementioned requirement, and the Governor has requested 67 additional positions to help meet the additional mandate of visiting each facility no less than once every five years.

- Last year, approximately 74,000 visits were made to CCLD licensed facilities and approximately 88,000 visits this fiscal year are projected – a 20 percent increase.

- The training Academy for the new monitoring and enforcement staff has been reinstituted. The Governor has included funds in his proposed 2006-07 budget for an expanded and updated version of the Academy, which will include training on the new automated reporting system and a more extensive component on complaint investigations.

- Automation efficiencies that reduce duplication of information and communicate licensing and enforcement findings to other governmental agencies have been purchased, and others are planned for the near future.

- Future plans for providing information regarding facility compliance on the web are also underway.

CCLD has the challenging job of licensing and providing oversight of more than 88,000 community care facilities with a capacity of 1.5 million people. The child care component alone represents 60,000 facilities with a capacity of 1.1 million children. We depend on our many community partners, parents, and others to provide us with valuable information and feedback to inform us of our improvements.

CHAPTER I: MONITORING AND OVERSIGHT

To ensure that the department continues to make monitoring visits, including periodic inspections and complaint visits, and carries out its other required responsibilities for child care facilities, the department should:

RECOMMENDATION #1:

Develop a plan to measure its random and required visits against statutory requirement to visit each facility once every five years and assess its progress in meeting the requirements. In addition, it should continue to assess its progress in meeting its other statutory visit requirements. Further, it should ensure that the data used to assess its progress in meeting the various requirements is reliable.

CDSS RESPONSE - 5/12/06:

We agree. With the approval of additional positions in the proposed Governor's budget, the CDSS will be positioned to meet the current statutory requirements. Now that we have two quarters of experience and data from the new reporting systems, first generation system glitches are being identified, and modifications are being pursued. A committee responsible for coordinating the databases, system testing, quality control and prioritization of improvements has already been meeting and will continue to address needed modifications on an ongoing basis.

The CDSS recognizes there are factors that affect the accuracy of the data we are reporting that need to be explored. Our multifaceted plan has been developed to improve the accuracy and reliability of the data and includes:

- A Field Automation System (FAS) modification implemented in January 2006, which required all facility inspection reports to be electronically signed will help to reduce duplicate reports.
- A special report is scheduled to be generated in the July – September quarter, which will identify the facilities that have not received any type of annual visit (i.e., annual, random, required, or triennial) since July 1, 2003, to ensure that those facilities receive a visit in order to comply with the five year requirement. This information will be used by the new field staff requested in the Governor's Budget to address this backlog issue.

- Training is a critical component. As we have indicated the need to rebuild, our internal training capacity is critical to the successful operation of our program.
    - o Short-term
        - ■ Instructions to remind all staff on usage of FAS that avoids the creation of duplicate reports will be issued immediately.
        - ■ An automation component has been integrated into the training academy, including specific instructions on completing and saving the licensing reports.
    - o Long-term
        - ■ Emphasize importance of accurate data input
        - ■ Include aforementioned issue in the development of the new supervisors training
        - ■ Develop ongoing technology training with specific instructions on completing and saving the licensing reports (resources are not currently available for this).

We will continue to monitor and assess our management information as we go forward with our rebuilding efforts. Workload and fiscal impact will be part of this assessment.

RECOMMENDATION #2:

Continue its efforts to rebuild the oversight operations of its Child Care Program and assess the sufficiency of its current monitoring efforts and statutory requirements to ensure the health and safety of children in care facilities. As part of its assessment, the department should evaluate whether its caseloads and frequency of periodic inspections are sufficient.

CDSS RESPONSE - 5/12/06:

We agree. The CDSS is committed to ensuring the safety of children in care. Child safety is one of the Governor's highest priorities. The administration has committed considerable resources and management oversight to improve and rebuild the CCLD.

- Last year, approximately 82 percent of the required visits were made, which included a ten percent random sample. This year, CCLD is projecting to exceed ten percent of the aforementioned requirement, and the Governor has requested 67 additional positions to help meet the additional mandate of visiting each facility no less than once every five years.

- Last year, approximately 74,000 visits were made to CCLD licensed facilities and approximately 88,000 visits this fiscal year are projected – a 20 percent increase.

Current statute requires the CDSS to report to the Legislature when the number of citations issued during a one year period increases by ten percent. This criterion to evaluate the health and safety of children in care was developed when comprehensive data was not available to assist policy makers in evaluating the efficacy of the visit protocol frequency and when resources were insufficient to make more frequent monitoring visits.

As information becomes available, the CDSS will evaluate and propose measures to best determine the efficacy of the current statutory visit protocol frequency. This is an issue which will require input from a range of stakeholders to effectively establish and implement a reliable measurement.

While visits are an important tool, some of the most valuable information about the quality of a licensed facility is obtained from parents and the local community, including law enforcement, provider organizations, resource and referral agencies, food programs, and placement agencies. Also, California has one of the most extensive and comprehensive background check processes in the nation and takes numerous preventive measures in processing applications for licensure. These and other tools must also be considered when determining the role of monitoring visits and the desirable frequency of these visits.

RECOMMENDATION #3:

Complete complaint investigations within the established 90-day period. In addition, the department should revise its policies to identify specific actions its child care program staff could take to reduce the number of inconclusive complaint findings. Further, the department should continue its plans to train all of its analysts in evaluating evidence and reaching conclusions on complaint allegations.

CDSS RESPONSE - 5/12/06:

We agree. It is important to have standards to ensure effective management of the complaint process. The CDSS is currently meeting the statutory requirement to make a visit within ten days of receiving a complaint. The CDSS has set an internal goal for completing complaint investigations within 90 days. This is a “best practice” standard, and we will continue to monitor toward this goal. Very serious complaints are given a higher priority, and those that could potentially result in a Temporary Suspension Order (TSO) receive the highest priority. There are times when investigations are a collaborative, multi-jurisdictional effort with law enforcement, child protective services, and/or the coroner’s office. In some cases, it may take longer than 90 days to obtain the evidence and associated case reports to complete the investigation.

Regional Managers track complaints that are taking longer than the 90-day goal for completion. With the addition of increased data collection, management oversight, many new staff, the Complaint Specialist/Investigator Team Pilot, and the Legal Cases Consultation Pilot, the program is in a better position to achieve this goal in the majority of cases.

For an example, an important goal of the Complaint Specialist/Investigator Team Pilot is to reduce the time it takes to conclude investigations for the most serious allegations worked by these teams. It is believed that by dividing duties between Complaint Specialists and Investigators and allowing each to focus on those parts of complaint investigations that, because of experience and training, he/she does best, complaint times can be shortened, and the 90-day goal can more often be met.

In conjunction with the pilot, the CDSS has also gone forward with a proposed reorganization of the Bureau of Investigations (BOI). The reorganization calls for an enhanced management structure that would allow for the necessary oversight of activities. Additionally, Investigators will be using the FAS which will allow for more timely availability and transmission of information. We are also collecting reliable data regarding complaint completion times by the team.

Response to complaints is the Division's highest priority and all recommendations for improvement in this area are appreciated. We have implemented the Complaint Specialist/Investigator Team Pilot, we continue to hire staff, we have expanded the complaint investigation module in the Training Academy for new staff, and we will be conducting advanced complaint training for all child care licensing staff. The plan is to provide an overview to the Child Care Regional Managers in June, 2006, train the licensing supervisors in July 2006, and then deliver the training to all child care field staff. The training will incorporate audit findings and will include several exercises regarding planning and conducting investigations, weighing evidence, and determining appropriate findings.

For the most serious complaints, the Complaint Specialist/Investigator teams are conducting the investigations. Protocols established for the pilot require discussion and agreement about how the investigation will be handled throughout the entire process, including determining findings. It is an important goal of the pilot to improve the quality of investigations and findings through teamwork and enhanced communications. The team also involves attorneys through the legal consultation process. The team, whenever possible, will carry the investigation to the point that a determination of unfounded or substantiated is reached, with the intent of minimizing the number of inconclusive findings. Also, inserting an enhanced management structure for BOI will allow for adequate review and guidance of investigative work by supervisors and will result in reduced inconclusive findings.

We will review the Evaluator Manual (EM) and determine if modifications are necessary.

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RECOMMENDATION #4

Evaluate its pilot project for supervisory approval after the plan of correction has been completed and implement a consistent process statewide for ensuring that licensees take appropriate corrective action.

CDSS RESPONSE - 5/12/06:

We agree. We will evaluate and implement the most effective process. Once a decision is made, procedures will be clarified in a directive memo to the management team.

RECOMMENDATION #5:

Provide specific guidance to its staff about whether deficiencies, such as those cited for absent or expired certifications for First Aid and Cardiopulmonary Resuscitation, should be categorized as a type A or B violation.

CDSS RESPONSE - 5/12/06:

We agree clarification is needed. Clarification will be incorporated into the EM and management will be informed as to how to implement the change.

RECOMMENDATION #6:

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

CDSS RESPONSE - 5/12/06:

We agree that it is important to have clear standards and expectations for plans of correction. Due to limited resources over the past several years, licensing staff were required to focus on meeting statutorily mandated requirements, with responding to complaints being the highest priority. Follow-up action on plans of correction were accomplished whenever possible.

It is important to note that the Bureau of State Audits recognized that CDSS did better follow-up to ensure that citations resulting from a complaint were corrected, as opposed to correction of citations resulting from an annual or required visit. Now that more information is available for parents on our website regarding licensing requirements and how to make a complaint, coupled with the requirement for providers to post any Type A violation as well as proof of correction, parents have been valuable partners in ensuring the protection of children in care.

We will assess where we are and take appropriate steps. The assessment will include an evaluation of how plans of correction are written and a review the EM. Plans for training will also be developed.

RECOMMENDATION #7:

Conduct a review of the complaint specialist pilot project in its regional offices. The review should include, at a minimum, the timeliness and appropriateness of actions taken since the project's implementation. The department should use the results of its review to determine how it should modify its existing processes.

CDSS RESPONSE - 5/12/06:

We agree that we should evaluate the timeliness of completing investigations as part of the Complaint Specialist/Investigator Pilot. The Pilot has been in progress less than a year and procedures are still being refined. Part of the evaluation of the Complaint Specialist/Investigator Team Pilot is determining whether the team can reduce investigation processing times and reduce the number of complaints pending over 90 days. Data has been collected since the pilot started on July 1, 2005 for the Complaint Specialists and the Investigators. Also, for BOI, a quality control review process is being implemented as part of the proposed reorganization and enhancement of management oversight. The quality control efforts will focus on timeliness and quality of the investigations and whether findings are correct.

We also agree that Complaint Specialists who are issuing citations and developing plans of correction with licensees should ensure that written plans of correction are meaningful and verifiable. Complaint Specialists will be included in any training provided to field staff regarding the development of appropriate plans of correction.

Under the pilot project, following the completion of the complaint investigation, the responsibility for follow-up is transferred back to the case carrying analyst. Additional protocols and guidance will be provided to Complaint Specialists and regional office staff to ensure appropriate transfer of the case and understanding of the roles and responsibilities related to follow-up.

RECOMMENDATION #8:

Develop sufficient automated management information to facilitate the effective oversight of its child care program regional offices.

CDSS RESPONSE - 5/12/06:

We agree that a better automated management information system is needed so that staff in the field can better track and manage their workload. Currently, front line staff and regional office management do not have automated tools to assist them in tracking, prioritizing, and managing

workload. We will continue to monitor, assess, and develop management information as we go forward with our rebuilding efforts. Workload and fiscal impact will have to be considered as we identify tools needed for our field staff.

RECOMMENDATION #9:

Continue its efforts to make all nonconfidential information about monitoring visits available to the public.

CDSS RESPONSE - 5/12/06:

We are currently in the process of developing an automation strategy, which includes putting public information regarding licensed facilities on the website. As the BSA noted, improvements need to be made concerning visits, documentation and complaint findings, measurable plans of correction, and automation technology. All of these elements are part of the rebuilding process and are critical to implementing information for parents/consumers that is reliable and valid. Implementation is dependent upon funding.

Attached is a chart, which reflects the information currently available on the website for parents, licensees, and the public in general. It is important to note that the regulations, EM, complaint forms, children's and parent's rights are available at this time. Tools are available to assist parents in assessing a quality child care facility. The CDSS provides a "facility search" tool to assist parents in locating programs.

CHAPTER II: ENFORCEMENT

To improve its enforcement actions in order to effectively address health and safety violations by child care facilities, the department should:

RECOMMENDATION #1:

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

CDSS RESPONSE - 5/12/06:

The CDSS is committed to ensuring that proper enforcement action is taken to protect children in care. Civil penalties are one valuable tool in enforcing health and safety requirements. Strong licensing systems include prevention (technical assistance, training, criminal background check clearance, etc.), compliance (monitoring visits, citations, plans of correction, etc), and enforcement (noncompliance conferences, temporary suspension orders, revocation, exclusions, etc.). Essential to effective enforcement is appropriate civil penalties.

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Consistent with Budget Committee supplemental report language, we will look at the data available and assess the civil penalty process. This assessment will include an evaluation of our policies and practices.

RECOMMENDATION #2:

Clarify its direction to regional office staff to help ensure that they are using noncompliance conferences promptly and in appropriate instances. Additionally, the department should reevaluate the May 3, 2004 memorandum and, to the extent that it reflects the department's current intent, incorporate the guidance into its evaluator manual. Further, the department should periodically review regional offices' use of noncompliance conferences to ensure that they are consistently following established policies.

CDSS RESPONSE - 5/12/06:

We agree to review the need for guidance and to evaluate and determine what information should be placed in the EM and assess the use of noncompliance conferences. It is important that the noncompliance conference be used to effect provider compliance. Staff and management need to function from the same understanding. The CDSS agrees to reevaluate the May 3, 2004 memo and issue appropriate guidance. The CDSS will evaluate how best to monitor regional office compliance with guidelines for the use of noncompliance conferences.

RECOMMENDATION #3:

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

CDSS RESPONSE - 5/12/06:

The CDSS agrees that early consultation with legal staff is beneficial. While legal consultation is currently available throughout the state, the Legal Division's Southern California Enforcement Section is currently conducting a consulting and training pilot project. Four attorneys are providing regular monthly consultations, as well as timely consultations throughout the month as needed. Early feedback indicates improved accessibility, consistency, and timeliness of consultations in the South. Legal consultation, utilization of the complaint specialist function, and management involvement (Regional Manager and Assistant Program Administrator) provides the CDSS with significant oversight and consistency in addressing complaints.

We will be evaluating this pilot in the next year and determining the feasibility of statewide implementation if the results prove positive.

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RECOMMENDATION #4:

Require follow-up monitoring visits to ensure that child care facilities with revoked licenses are not operating and that individuals excluded from facilities are not present in the facilities. The department should also revise its policies for following up on excluded individuals to ensure that it more promptly verifies that they are not present in facilities.

CDSS RESPONSE - 5/12/06:

The CDSS agrees to assess this finding.

Currently, the Regional Manager assesses the need for follow-up visits. Often they are conducted. The CDSS understands the importance of ensuring that services have stopped or individuals are excluded. For Temporary Suspension Orders (TSO), parents are notified and the Resource and Referral Agency is informed. A TSO notice is posted on the door, and it is a misdemeanor and a $500 fine if removed. For exclusions, providers are required to notify parents and are subject to immediate civil penalties for failure to do so.

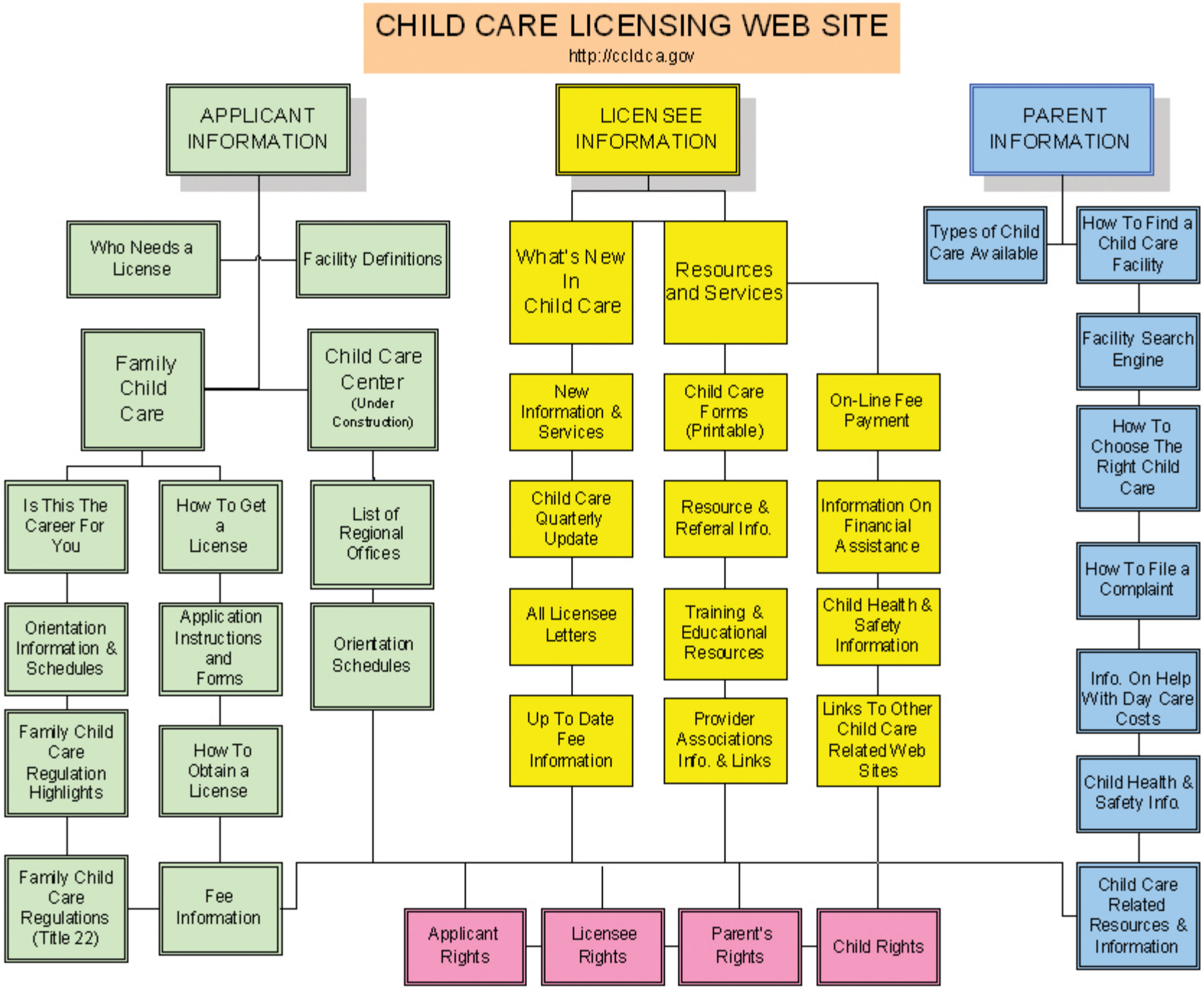
This assessment will include how to best follow up to ensure a facility has stopped operation and/or the excluded individual is out of the facility, how to best ensure parents and the public are aware of the action, and any associated fiscal and workload impact.

RECOMMENDATION #5:

Ensure that visits to facilities on probation are made within the required deadline.

CDSS RESPONSE - 5/12/06:

We agree and will assess the tools used to ensure that staff is aware that a visit is required and made. Management will be directed to review with staff during all staff meetings.


CHILD CARE LICENSING WEB SITE
http://ccld.ca.gov
APPLICANT INFORMATION
LICENSEE INFORMATION
PARENT INFORMATION
Who Needs a License
Facility Definitions
Family Child Care
Child Care Center (Under Construction)
Is This The Career For You
How To Get a License
List of Regional Offices
Orientation Information & Schedules
Application Instructions and Forms
Orientation Schedules
Family Child Care Regulation Highlights
How To Obtain a License
Family Child Care Regulations (Title 22)
Fee Information
What's New In Child Care
Resources and Services
New Information & Services
Child Care Forms (Printable)
On-Line Fee Payment
Child Care Quarterly Update
Resource & Referral Info.
Information On Financial Assistance
All Licensee Letters
Training & Educational Resources
Child Health & Safety Information
Up To Date Fee Information
Provider Associations Info. & Links
Links To Other Child Care Related Web Sites
Types of Child Care Available
How To Find a Child Care Facility
Facility Search Engine
How To Choose The Right Child Care
How To File a Complaint
Info. On Help With Day Care Costs
Child Health & Safety Info.
Applicant Rights
Licensee Rights
Parent's Rights
Child Rights
Child Care Related Resources & Information

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