DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Memorandum

Date JAN 11 2001

From Michael Mangano
Acting Inspector General

Subject Review of the Adequacy of State Procedures for the Oversight of Douglas House and Youth Continuum, Inc. (A-01-00-02504)

To

Olivia A. Golden
Assistant Secretary
for Children and Families

This is to alert you to the issuance of our final report on January 16, 2001. A copy is attached. This review was requested through U.S. Representative Rosa L. DeLauro's staff on March 2, 2000. The objective of our review was to determine if the Connecticut Department of Children and Families (DCF) policies and procedures provide adequate oversight of Douglas House and Youth Continuum, Inc. (YC) facilities. Our review was conducted at DCF in Hartford, Connecticut.

While Connecticut has enacted legislation for licensing and monitoring child care facilities, our analysis shows a history of systemic weaknesses in DCF's oversight processes, including those at Douglas House and other providers. Accordingly, we question whether adequate oversight was provided by DCF in the most effective and efficient manner. In order to ensure the safety of children entrusted in the State's care, these weaknesses should be corrected. Below is a summary of the areas we identified.

- We found that DCF's inspection and reporting process needs improvement, especially in the areas of performing quarterly visits required by State law, reporting results, and documenting supervisory reviews. For example, Douglas House was inspected only 4 times from October 1995 to October 1999, when 17 inspections should have been performed (3 license renewals and 14 periodic visits). The inspections that were performed included three license renewals and possibly one quarterly visit. However, DCF could not locate the inspection report for the quarterly visit. We also noted instances when inspectors reported that certain licensing requirements had been met when the documented evidence suggested otherwise. Also, 19 of 23 inspection reports we reviewed for inspections conducted between October 1995 and March 2000 did not show evidence of supervisory review.

- Regular operating licenses were issued and reissued to Douglas House and other YC facilities regardless of serious deficiencies identified by license inspectors. Also, corrective actions by these facilities have not been taken. The Connecticut Child Advocate, for example, identified in November 1999 the same serious health and

licensing violations inspectors identified in October 1996 for Douglas House. Yet this facility has received an operating license since at least December 1995. Further, DCF regulations allow inspectors to issue provisional licenses when conditions can be corrected with minimal effort. However, current procedures do not provide sufficient guidance for what constitutes such conditions. Finally, the processes and conditions for suspending, revoking or refusing to renew a license have not been defined in written procedures. We believe that without deterrents or penalties, other than the consequence of revoking a license in a time when the number of child care facilities is limited, there appears to be no incentive for child care providers to fully meet licensing standards and/or correct deficiencies identified by license inspectors in a timely manner.

- The DCF's internal licensing functions do not analyze incoming hotline reports to initiate inspections for facilities with significant or a high number of investigations. We believe that analyzing hotline reports could be beneficial since about one-third of hotline investigations at licensed shelters in 1999 were related to Douglas House.

Although DCF is in the process of taking steps to improve its regulations and procedures, we believe that additional improvements are needed in its oversight responsibilities to adequately resolve the weaknesses we identified. Accordingly, we recommend that DCF:

- Fully adopt proposed procedures for periodic/quarterly visits of child care facilities and implement a process for ensuring that these interim inspections take place. Adopted procedures should also include standard guidelines for the consistent reporting of results and require documented supervisory review of inspection reports.

- Revise its regulations to provide guidelines to license inspectors for determining conditions that can and cannot be corrected with minimal effort, and establish criteria for suspending, revoking or refusing to renew a license. Also, ensure that the draft regulations require child care providers to develop and implement corrective action plans within established time frames, require license inspectors to perform follow-up visits to verify that providers have implemented corrective actions, and establish a system of penalties if providers fail to correct identified deficiencies.

- Establish procedures to require an analysis of hotline reports and perform subsequent inspections as needed.

The DCF officials stated their commitment to improving the quality of care to Connecticut's children and has taken steps toward implementing our recommendations (See Appendix 2). These steps include: (1) developing and implementing a formal process to conduct quarterly visits of child care agencies, (2) hiring an additional licensing inspector, (3) developing stringent regulations which will govern licensing actions and require the implementation of corrective action plans for deficiencies identified at child care agencies, (4) implementing a

process to review hotline reports and perform subsequent inspections when warranted, and (5) developing procedures and guidelines for the consistent reporting of inspection activities and supervisory review of inspection reports. Further, DCF has closely supervised the corrective actions taken by Douglas House and YC and agrees that it must hold child care agencies accountable to provide the highest quality of care, and agencies must serve children with respect and dignity.

Any questions or comments on any aspects of this memorandum are welcome. Please call me or have your staff contact Donald L. Dille, Assistant Inspector General for Administrations of Children, Family, and Aging Audits at (202) 619-1175.

Attachment

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

ADEQUACY OF STATE PROCEDURES FOR THE OVERSIGHT OF DOUGLAS HOUSE AND YOUTH CONTINUUM, INC.

Inspector General

JANUARY 2001
A-01-00-02504

DEPARTMENT OF HEALTH & HUMAN SERVICES OFFICE OF INSPECTOR GENERAL

Office of Audit Services
Region I
John F. Kennedy Federal Building
Boston, MA 02203
(617) 565-2684

Ms. Kristine D. Ragaglia
Commissioner
Connecticut Department of Children and Families
505 Hudson Street
Hartford, Connecticut 06106

Dear Ms. Ragaglia:

Enclosed are two copies of the U.S. Department of Health and Human Services, Office of Inspector General, Office of Audit Services' report entitled "Adequacy of State Procedures for the Oversight of Douglas House and Youth Continuum, Inc." A copy of this report will be forwarded to the action official below for his review and any action deemed necessary.

Final determination as to actions taken on all matters reported will be made by the HHS action official named below. We request that you respond to the HHS action official within 30 days from the date of this letter. Your response should present any comments or additional information that you believe may have a bearing on the final determination.

In accordance with the principles of the Freedom of Information Act (Public Law 90-23), OIG, OAS reports issued to the Department's grantees and contractors are made available to members of the press and general public to the extent information contained therein is not subject to exemptions in the Act which the Department chooses to exercise. (See 45 CFR Part 5.) To facilitate identification, please refer to Common Identification Number A-01-00-02504 in all correspondence relating to this report.

Sincerely yours,

Michael J. Armstrong
Regional Inspector General
for Audit Services

Enclosures - as stated

Direct Reply to HHS Action Official:

Mr. Hugh F. Galligan, Regional Administrator
Administration for Children and Families
US Department of Health and Human Services
John F. Kennedy Federal Building, Room 2000
Boston, Massachusetts 02203

BACKGROUND

Connecticut's regulations for the operation of child care agencies and facilities define a child care facility as a child's home or similar institution that provides for the boarding or care of a child. The Department for Children and Families (DCF) is responsible for administering and monitoring these homes and institutions to ensure that safety, health and operating standards are met.

On November 10, 1999, the Connecticut Child Advocate, a State official independent of DCF, made an unannounced visit at the Douglas House, an emergency shelter administered by Youth Continuum, Inc. (YC). It reported deplorable conditions, including roach infestation, rodent feces, exposed electrical wires and pipes, overflowing garbage throughout the house, and filthy clothes thrown into piles. Based on the report, the Office of Inspector General received a congressional request to perform an independent review of DCF's oversight procedures for Douglas House and other YC facilities.

OBJECTIVE

The objective of our review was to determine if DCF policies and procedures provide adequate oversight of Douglas House and other YC facilities.

SUMMARY OF FINDINGS

While Connecticut has enacted legislation for licensing and monitoring child care facilities, our analysis shows a history of systemic weaknesses in DCF's oversight processes, including those at Douglas House and other providers. Accordingly, we question whether adequate oversight was provided by DCF in the most effective and efficient manner. Below is a summary of the areas we identified.

- We found that DCF's inspection and reporting process needs improvement, especially in the areas of performing quarterly visits required by State law, reporting results, and documenting supervisory reviews. For example, Douglas House was inspected only 4 times from October 1995 to October 1999, when 17 should have been performed (3 license renewals and 14 periodic visits). The inspections that were performed included three license renewals and possibly one quarterly visit. However, DCF could not locate the inspection report for the quarterly visit. We also noted instances when inspectors reported that certain licensing requirements had been met when the documented evidence suggested otherwise, and 19 of 23 inspection reports we reviewed for inspections conducted between October 1995 and March 2000 did not show evidence of supervisory review.

- Regular operating licenses were issued and reissued to Douglas House and other YC facilities regardless of serious deficiencies identified by license inspectors. Also, corrective actions by these facilities have not been taken. The Connecticut Child Advocate, for example, identified in November 1999 the same serious health and licensing violations inspectors identified in October 1996 for Douglas House. Yet this facility has received an operating license since at least

December 1995. Further, DCF regulations allow inspectors to issue provisional licenses when conditions can be corrected with minimal effort. However, current procedures do not provide sufficient guidance for what constitutes such conditions. Finally, the processes and conditions for suspending, revoking or refusing to renew a license have not been defined in written procedures. We believe that without deterrents or penalties, other than the consequence of revoking a license in a time when the number of child care facilities is limited, there appears to be no incentive for child care providers to fully meet licensing standards and/or correct deficiencies identified by license inspectors in a timely manner.

- The DCF's internal licensing functions do not analyze incoming hotline reports to initiate inspections for facilities with significant or a high number of investigations. We believe that analyzing hotline reports could be beneficial since about one-third of hotline investigations at licensed shelters in 1999 were related to Douglas House.

In order to ensure the safety of children entrusted in the State's care, these weaknesses should be corrected.

RECOMMENDATIONS

Although DCF is in the process of taking steps to improve its regulations and procedures, we believe that additional improvements are needed in its oversight responsibilities to adequately resolve the weaknesses we identified. Accordingly, we recommend that DCF:

- Fully adopt proposed procedures for periodic/quarterly visits of child care facilities and implement a process for ensuring that these interim inspections take place. Adopted procedures should also include standard guidelines for the consistent reporting of results and require documented supervisory review of inspection reports.

- Revise its regulations to provide guidelines to license inspectors for determining conditions that can and cannot be corrected with minimal effort, and establish criteria for suspending, revoking or refusing to renew a license. Also, ensure that the draft regulations require child care providers to develop and implement corrective action plans within established time frames, require license inspectors to perform follow-up visits to verify that providers have implemented corrective actions, and establish a system of penalties if providers fail to correct identified deficiencies.

- Establish procedures to require an analysis of hotline reports and perform subsequent inspections as needed.

STATE AGENCY COMMENTS

The DCF officials stated that they are committed to improving the quality of care to Connecticut's children and has taken steps toward implementing our recommendations (See Appendix 2). These steps include: (1) developing and implementing a formal process to conduct quarterly visits for child care agencies, (2) hiring an additional licensing inspector, (3) developing stringent regulations which will govern licensing actions and require the implementation of corrective action plans for deficiencies identified at child care agencies, (4) implementing a process to review hotline reports and perform subsequent inspections when warranted, and (5) developing procedures and guidelines for the consistent reporting of inspection activities and supervisory review of inspection reports.

Further, DCF has closely supervised the corrective actions taken by Douglas House and YC and agrees that it must hold child care agencies accountable to provide the highest quality of care, and agencies must serve children with respect and dignity.

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APPENDIX 2 - Department of Children and Families Comments to Draft Report

INTRODUCTION

BACKGROUND

Connecticut's Child Advocate found deplorable conditions at Douglas House, an emergency shelter administered by Youth Continuum, Inc., (YC), during an unannounced visit on November 10, 1999. Identified conditions included roach infestation, rodent feces, exposed electrical wires and pipes, overflowing garbage throughout the house, and filthy clothes thrown into piles. Accordingly, a U.S. Representative requested the Office of Inspector General to perform an independent review of the Department for Children and Families (DCF) oversight procedures for Douglas House and other YC facilities.

The Office of the Child Advocate (OCA) is an independent State agency that was established in 1995 to protect the civil, legal and special rights of all the children of Connecticut, and to advance policies throughout the State that promote their well-being and best interests. Among its duties, OCA is responsible for reviewing complaints concerning the actions of any State agency providing services to children or any entity that provides services with funds provided by the State.

The YC is a private, non-profit, community based, multi-service agency providing shelter, group home, transitional living, and prevention services to youth 3-24 years of age throughout Connecticut. Its first facility was licensed by DCF in 1973. Currently, YC operates six child care residential facilities licensed to operate in Connecticut, including Douglas House. These facilities consist of three temporary shelters, two group homes, and one residential treatment facility. Based on its most recently audited financial statements for fiscal year ended June 30, 1999, YC received most of its funding in grants from Federal, State and local governmental agencies or community organizations. Direct grants from the Department of Health and Human Services in Fiscal Year 1999 included $79,204 from the Runaway Youth Program and $103,966 from the Street Outreach Program. A large part of the funding for YC is from the State's juvenile justice and Foster Care programs.

The DCF is responsible for administering the Foster Care program in Connecticut. A significant part of the State's foster care expenditures are claimed for Federal reimbursement under the Title IV-E Foster Care program. The IV-E program was authorized in 1980 under title IV-E of the Social Security Act, Section 470 et seq. (42 U.S.C. 670 et seq.). Its purpose is to help States provide proper care for children who need placement outside their homes, in a foster family home or institution. The Foster Care program provides funds to States to assist them with the cost of providing care for eligible children. The statute requires that, to be considered a foster family home for the purpose of Title IV-E eligibility, the home must be either licensed or approved as meeting State licensing statutes. In addition, the Adoption and Safe Families Act of 1997 makes it clear that children's health and safety are the paramount concerns of our public child welfare system.

The DCF's organizational structure includes the Licensing Unit, which is responsible for the inspection and licensing of the State's child care facilities (See Appendix for DCF's Organization Chart). The DCF's licensing regulations define a child care facility as a child's home or similar institution, which provides for the boarding or care of a child. These facilities include treatment facilities, group homes, temporary shelters, foster homes, adoptive homes, and family day care homes. An individual, a group of individuals, or a corporation may administer a facility. This

includes the oversight of child care facilities, child placement agencies, extended day treatment programs, permanent family residences, and child outpatient psychiatric clinics. Six license inspectors currently handle the Licensing Unit's workload which, as of March 15, 2000, consists of a total 162 licensed providers including 72 licensed child care providers.

The DCF has taken action to address the deficiencies and violations that occurred at Douglas House. Specifically, it has drafted licensing regulations and inspection procedures to prevent similar instances from occurring.

OBJECTIVE, SCOPE, AND METHODOLOGY

OBJECTIVE

The objective of our review was to determine if DCF regulations, policies and procedures provide adequate oversight of Douglas House and other YC facilities.

SCOPE

Our review was performed in accordance with generally accepted government auditing standards. Our assessment of the internal controls was primarily limited to the review of DCF's licensing process for Douglas House and other YC facilities.

METHODOLOGY

To accomplish our objective, we:

- Reviewed applicable Federal and State laws, regulations, policies and procedures.
- Interviewed individuals from the State's OCA.
- Reviewed State contracts with Douglas House and other YC facilities.
- Reviewed current and prior inspection reports for Douglas House and other YC facilities.
- Reviewed corrective actions taken by YC management in response to conditions found by the State's Child Advocate.
- Reviewed DCF's corrective actions for the licensing and oversight of child care facilities.
- Conducted an unannounced visit to Douglas House.
- Interviewed hotline officials and obtained summary information on hotline investigations for Douglas House and other YC facilities.

We performed our fieldwork at DCF in Hartford, Connecticut, between March and May 2000. We discussed the results of our review with DCF officials on October 6, 2000. The DCF's written response to the draft report was received on December 6, 2000 (See Appendix 2).

FINDINGS AND RECOMMENDATIONS

While Connecticut has enacted legislation for licensing and monitoring child care facilities, we found a history of systemic weaknesses in these processes, including those at the provider level. Below is a summary of the areas we identified.

- The DCF's inspection and reporting process needs improvement, especially in the areas of performing quarterly visits, reporting results, and documenting supervisory reviews.
- Regular operating licenses were issued and reissued regardless of serious and uncorrected deficiencies identified by license inspectors.
- The DCF's internal licensing functions do not analyze incoming hotline reports to initiate inspections for facilities with significant or a high number of investigations.

Based on our analysis, we question whether adequate oversight was provided by DCF in the most effective and efficient manner. In order to ensure the safety of children entrusted in the State's care, these weaknesses should be corrected.

In its response, DCF officials state that they are committed to improving the quality of care to Connecticut's children and has taken steps to address these weaknesses. The DCF has moved to improve its oversight and monitoring activities. Further, DCF has closely supervised the corrective actions taken by Douglas House and YC and agrees that it must hold child care agencies accountable to provide the highest quality of care, and agencies must serve children with respect and dignity.

DCF'S INSPECTION AND REPORTING PROCESS NEEDS IMPROVING

Our review disclosed that DCF's inspection and reporting process needs improvement, especially when periodic inspections have not been performed although required, there are no formalized written procedures for reporting results, and supervisory reviews are not consistently documented.

Periodic Inspections Not Conducted As Required

Our review of inspection records for Douglas House and other YC facilities disclosed that periodic inspection visits have not been performed although required. State law, effective 1961, requires DCF's Commissioner to perform periodic safety and health inspections not to exceed 90-day intervals. Periodic visits are separate from license renewal inspections that are done once every 2 years. We found that existing DCF regulations do not include provisions for periodic inspections. We learned from license inspectors that quarterly field visits had been conducted in prior years. However, these periodic visits have not been performed since 1995 due to increases in workload and decreases in staff. The DCF has recently drafted procedures that specify two announced and two unannounced visits per year. We believe that periodic visits should improve DCF's effectiveness in maintaining child care facilities and prevent living conditions from deteriorating.

Connecticut General Statutes, Part II, Section 17a-151, states that:

> "The commissioner shall also provide such periodic inspection and review as shall safeguard the well-being, health and morality of all children cared for or placed under a license issued by him hereunder and shall visit and consult with each such child and with the licensee as often as he deems necessary but at intervals of not more than ninety days...."

A periodic inspection takes one inspector about a day to complete. These visits can be conducted on an announced or unannounced basis. The extent and type of periodic inspection is based on the inspector's professional judgement. This is different from a full license inspection in which two to four inspectors take 3 to 4 days to adequately fulfill a standard list of items or issues to be covered.

We found that Douglas House was inspected only four times from October 1995 to October 1999. The inspections included three license renewals and possibly one periodic visit. However, DCF could not locate the field report for the periodic visit. We found no evidence of any unannounced inspections by DCF during this 4-year period. If periodic inspections had been done quarterly, DCF inspectors would have visited Douglas House 17 times during this period (3 license renewals and 14 periodic visits). Instead, Douglas House went without an inspection of any kind between October 1996 and November 1998. Also, we noted that the required number of periodic inspections had not been performed for four other YC facilities from November 1997 through April 2000.

During 1995, Connecticut's legislation extended the licensing term of child care providers from 1 to 2 years. This further emphasized the need for periodic visits. However, DCF officials informed us that increases in the workload for 1995, combined with decreases in inspectors required the reallocation of staff to other areas and the quarterly visits stopped. We found that, to date, DCF has not established operating procedures for the Licensing Unit. Recently, DCF has added staff to revamp this process and drafted procedures that specify two announced and two unannounced visits per year. The draft procedures also require inspectors to observe and interview staff and residents as part of each visit.

No Formalized Written Procedures For Reporting Results

Our review disclosed that DCF's current license inspection process does not include formalized written procedures for reporting results. Specifically, the current process differs in how results are reported for new licenses and renewals. Also, we found that the inspection reports for license renewals at Douglas House and other YC facilities included inconsistent information. Accordingly, DCF's inspection reports may not consistently reflect actual conditions at child care facilities.

Inspection Results Not Fully Documented

We found that the results of inspections for new facilities were not fully documented. Instead, inspectors only issue an informal one or two page summary of their results, including comments on areas that need corrective action. In contrast, we found the results for license renewals are fully documented in DCF's Child Care Facility Inspection Report, a 22-page standard document. This

report is primarily a checklist of all licensing requirements and related regulatory citations a facility must comply with to be relicensed. Beginning in 1997, inspectors were also required to complete a 4-page medical administration addendum.

We believe that the inspection report and medical administration addendum should be used to document the inspection of new facilities, especially since licensing regulations for new facilities and renewals are essentially the same. We are concerned that informal write-ups may give the wrong impression of facility conditions when inspectors do not fully document their results. Further, inspectors may inadvertently overlook a license requirement when the inspection report is not used. The DCF officials have agreed to use the inspection report to document the results of all license inspections.

Inconsistent Information Included in Reported Results

License inspection reports for Douglas House and other YC facilities included significant inconsistencies. As stated above, DCF does have a standard inspection report that serves as a checklist of licensing requirements. However, our review of the inspection reports for Douglas House and other YC facilities noted instances when inspectors had confirmed that a certain licensing requirement had been met when documented evidence suggested otherwise. Specific examples of inconsistent results include the below incidents.

Example 1: DCF licensing regulations require child care facilities to: (i) have clearly written operating polices and procedures in place, (ii) review these policies and procedures no less than annually and update them as necessary, and (iii) inform and provide facility staff with updated requirements. Our review of the December 1998 inspection report for Douglas House noted that these requirements had been marked as being met. However, an interview with a Douglas House official indicated that other than a marketing pamphlet for residents, no formal policies and procedures had been Board approved and issued. Although the lead inspector for the December 1998 license inspection is no longer with the Licensing Unit, an inspector who assisted in the inspection did not recall Douglas House having any formal policies and procedures in place. Similar inconsistencies were noted in our review of the license inspection reports for three other YC facilities. While DCF officials informed us that YC has procedures in place for managing its facilities, we noted that as of June 1, 2000 operating procedures for Douglas House had been drafted but not approved by YC's Board nor given to facility staff. As stated above, DCF's child care regulations require written operating procedures at the facility level.

Example 2: DCF's licensing regulations do not allow a facility to exceed its license bed capacity without prior approval. We found that in one section of the December 1998 inspection report, Douglas House had exceeded the current licensed bed capacity by one child. Yet in another section of the report, the inspector concluded that bed capacity had not been exceeded. The DCF officials could not provide an explanation for this inconsistency, and we did not find any evidence that DCF had approved an increase in bed capacity.

Documented Supervisory Reviews of Inspection Reports

Our review found that DCF license inspection reports lacked evidence of supervisory review. The DCF has not established procedures that require inspection reports to be submitted and signed by a supervisor. Interviews with license inspectors disclosed that they currently submit full license inspection reports for supervisory review. However, 19 of the 23 reports we reviewed for inspections conducted between October 1995 and March 2000 did not show evidence of supervisory review. Specifically, 6 of the 8 full inspection reports did not include documented evidence that they had been reviewed, as well as 13 out of 15 reports for field visits. Of the 15 field visit reports for YC facilities, 12 of these reports were conducted subsequent to the November 10, 1999 Child Advocate's visit to Douglas House. We believe that all reports should include evidence of a supervisory review to ensure that they comply with procedures, and any identified deficiencies have been appropriately surfaced and handled. The DCF officials have agreed to do this.

LICENSES ISSUED WHEN SERIOUS DEFICIENCIES EXISTED

We found that DCF issued regular operating licenses to Douglas House and other YC facilities regardless of serious deficiencies that remained uncorrected from 2 to 5 years. State law allows DCF to issue either a regular operating license when all requirements have been met or a provisional license when minimal effort is needed to fully comply with all licensing regulations. We found that existing regulations, in effect since 1981, do not include guidelines for determining conditions that can be corrected with minimal effort. Further, they do not require DCF to work with deficient facilities in developing and implementing corrective action plans within specified time frames. Instead, they leave the process for suspending, revoking or refusing to renew a license to the judgement of the commissioner or his/her designee. Finally, existing regulations do not include a provision for penalizing providers that fail to resolve serious deficiencies in a timely manner.

Connecticut General Statutes, Part II, Section 17a-151, states that:

> "The Commissioner of Children and Families shall investigate the conditions stated in each application made to him...and, if the commissioner finds such conditions suitable for the proper care of children, or for the placing of children, under such standards for the promotion of the health, safety, morality, and well-being of such children as he prescribes, shall issue such license as is required promptly as possible, without expense to the licensee. If after his investigation the commissioner finds that the applicant, notwithstanding good faith efforts, is not able to **fully comply with all the requirements** (emphasis added) he prescribes, but compliance can be achieved with minimal efforts, the commissioner may issue a provisional license for a period not to exceed sixty days."

Further, Section 17a-145-61 of DCF's regulations states that:

> "The policies and operating procedures of the **facility** (emphasis added) covering the selection, medical care, education, religious training, discipline, discharge, program, daily care, feeding, staffing pattern and supervision of the children shall be

clearly stated in writing, reviewed no less than annually by the persons responsible for the total operation of the facility, and kept current. Copies and any subsequent revision thereof shall be made available to appropriate staff of the facility. Copies of any subsequent substantial revisions shall be provided to the department."

We obtained a copy of the draft operating procedures for Douglas House in March 2000. A Douglas House official stated that this undated draft version is awaiting Board approval and has not been issued. The Douglas House operating procedures subsequently furnished to us by DCF on October 20, 2000 contained no changes when compared to the March 2000 version. Both copies are undated and unsigned. Even though no changes were made since the March 2000 version, the DCF inspector indicated that as of October 27, 2000 the operating procedures have still not been approved by the Board as required. Our review of the 64 page draft document shows that it contains important provisions addressing responsibilities and expectation in critical areas. One of these critical areas includes facility maintenance and sanitation policy. The procedures contains staff requirements for weekly sanitation and safety inspections and addresses garbage disposal, cleaning of the facility, rodents and other vermin, clean linen and laundry procedures, repairs and preventative maintenance. We found no evidence that DCF has been forceful on the issuance of policies and procedures for Douglas House or any of the other five facilities.

Our review of inspection reports for Douglas House identified serious deficiencies that remained uncorrected between 2 and 5 years, yet this child care facility has received a regular operating license since at least December 1995. Recommendations made by license inspectors to correct identified deficiencies included: (i) establish approved written procedures for medical administration (e.g., giving residents medication by means other than injection), (ii) ensure the safety of children by complying with DCF's medical administration guidelines, and (iii) establish approved facility operating policies and procedures. All three recommendations have remained uncorrected since October 1996. Also, the December 1998 inspection report included a finding of unsafe bathroom water temperatures. As of the February 10, 2000, we found no evidence of a DCF follow-up inspection to ensure that this unsafe hot water condition had been corrected.

We question whether Douglas House and other facilities should have been licensed or re-licensed when these and the below conditions appear to require more than minimal effort to resolve.

Example 1: The following health and safety issues for Douglas House were highlighted by the health inspector's report for October 1996 and the OCA in November 1999:

- the presence of insects and rodents;
- floors and walls were in poor condition;
- the premises were not free of litter and unnecessary articles; and
- clean and soiled linens were not stored properly.

Example 2: A June 24, 1999, license inspection uncovered 37 deficiencies for a recently launched facility. Since YC's first licensed facility in 1973, DCF has assisted YC in complying with licensing regulations. This means that YC has had 26 years of

experience in administering child care facilities including knowledge of DCF licensing requirements which have not changed since 1981. While DCF licensing officials could not locate the inspection report for this facility, its corrective action plan, dated June 28, 1999, disclosed that many of the 37 deficiencies related to health and safety issues. These deficiencies included:

- failure to obtain a proper certification from the local fire marshal;
- serious leaking of hot water tank;
- absence of locked medical storage cabinet;
- circuit box exposed in living room;
- dishes and linen need to be purchased, and bedrooms were not furnished;
- no garbage cans;
- no treatment plans or progress notes in client files; and
- police and DCF background checks for employees were not completed.

The DCF officials stated that the State should not have to expend its limited resources on what is essentially YC's responsibility - preparing a facility for an inspection. However, DCF management had not met with YC as of June 1, 2000, to express their concern with the inspection results and to determine the root cause for why there were so many deficiencies. On July 20, 1999, this facility was issued a provisional license. Lacking evidence of a DCF follow-up inspection, we were unable to determine the number of deficiencies that were corrected before issuance of the provisional license. On December 27, 1999, the field inspection report recommended and the facility received a regular operating license even though significant deficiencies remained uncorrected. Specifically, the field inspection report noted that operating procedures had still not been approved by YC's Board of Directors. In addition, quarterly reviews of the medication administration section of these operating procedures relating to the proper care and treatment of children with minor injuries and illnesses have not been performed although required.

To the credit of DCF officials, they have acknowledged the weaknesses in the current licensing regulations and procedures and have revamped their efforts to revise them. Our review of DCF's draft regulations and procedures found that they would be even more effective if they provided guidelines to license inspectors for determining conditions that can and cannot be corrected with minimal effort, and establish criteria for suspending, revoking or refusing to renew a license. Criteria to consider includes the number of deficiencies identified in prior inspections, the number of repeated deficiencies, and the expediency in correcting deficiencies. While the draft regulations do require deficient facilities to develop and implement corrective action plans within established time frames, there is no requirement that a follow-up visit should be done to verify compliance nor are there any penalties if providers fail to comply.

THE ANALYSIS OF HOTLINE REPORTS TO INITIATE INSPECTIONS

Our review disclosed that DCF's current license inspection process does not include the analysis of hotline reports to initiate inspections for facilities with significant or a high number of incidents. This could be a beneficial process since one-third of the hotline investigations for licensed shelters in 1999

were related to Douglas House. The DCF officials indicated that they have recently taken action to identify and summarize hotline data so that provider information can be analyzed and trended.

The DCF's hotline is a centralized function that receives all telephone calls or written information alleging that a child has been abused, neglected, or is in danger of being abused. It is open 24 hours a day, 365 days a year. Based on incoming information, hotline staff performs expedient investigations of abuse or neglect at various settings, including child care facilities, and issues a detailed report of their findings to DCF's Program Review and Evaluation Unit (PREU).

The PREU is responsible for conducting studies of any program, service or facility developed, operated, contracted for or supported by DCF in order to evaluate its effectiveness. One source of information it receives is hotline reports. We found that PREU has no written operating procedures in place, and could not locate all reports it has received from the hotline. In fact, we noted that PREU's day-to-day operations do not include an evaluation of hotline reports, such as a routine trend analysis to identify those child care facilities with significant or a high number of incidents. Based on our inquiries, DCF officials met with hotline officials to identify the types of information that could be used to enhance the licensing process and oversight of child care facilities. The PREU has since started the process of tracking and summarizing all incoming hotline reports. They plan to follow up with named facilities to develop a corrective action plan.

CONCLUSION

The results of our review showed that significant systemic weaknesses exist in DCF's oversight of YC facilities and potentially other provider care facilities. The Adoption and Safe Families Act of 1997 makes it clear that children's health and safety are the paramount concerns of our public child welfare system and that good child care provides important safe havens for the children. We believe that this includes establishing and regularly following policies and procedures at both the provider and State agency levels. Periodic visits, both announced and unannounced, are essential for ensuring that child care providers follow approved operating procedures and living conditions for foster children do not deteriorate. Also contributing to the need for periodic visits was Connecticut's shift in licensing terms from 1 to 2 years. Clear licensing guidelines that have been integrated into the culture and operations of DCF will more than likely limit the number of incidents where operating licenses are awarded to child care providers that have fallen short of minimum safety, health and operating standards. Monitoring, including the regular analysis of hotline reports and supervisory reviews for consistent and accurate reports, sends the message that DCF will not accept substandard conditions for facilities nor inconsistent reporting of inspection results.

RECOMMENDATIONS

Although DCF is in the process of taking steps to improve its regulations and procedures, we believe that additional improvements are needed to adequately resolve the weaknesses we identified. Accordingly, we recommend that DCF:

- Fully adopt proposed procedures for periodic/quarterly visits of child care facilities and implement a process for ensuring that these interim inspections take place. Adopted procedures should also include standard guidelines for the consistent reporting of results and require documented supervisory review of inspection reports.

- Revise its regulations to provide guidelines to license inspectors for determining conditions that can and cannot be corrected with minimal effort, and establish criteria for suspending, revoking or refusing to renew a license. Also, ensure that the draft regulations require child care providers to develop and implement corrective action plans within established time frames, require license inspectors to perform follow-up visits to verify that providers have implemented corrective actions, and establish a system of penalties if providers fail to correct identified deficiencies.

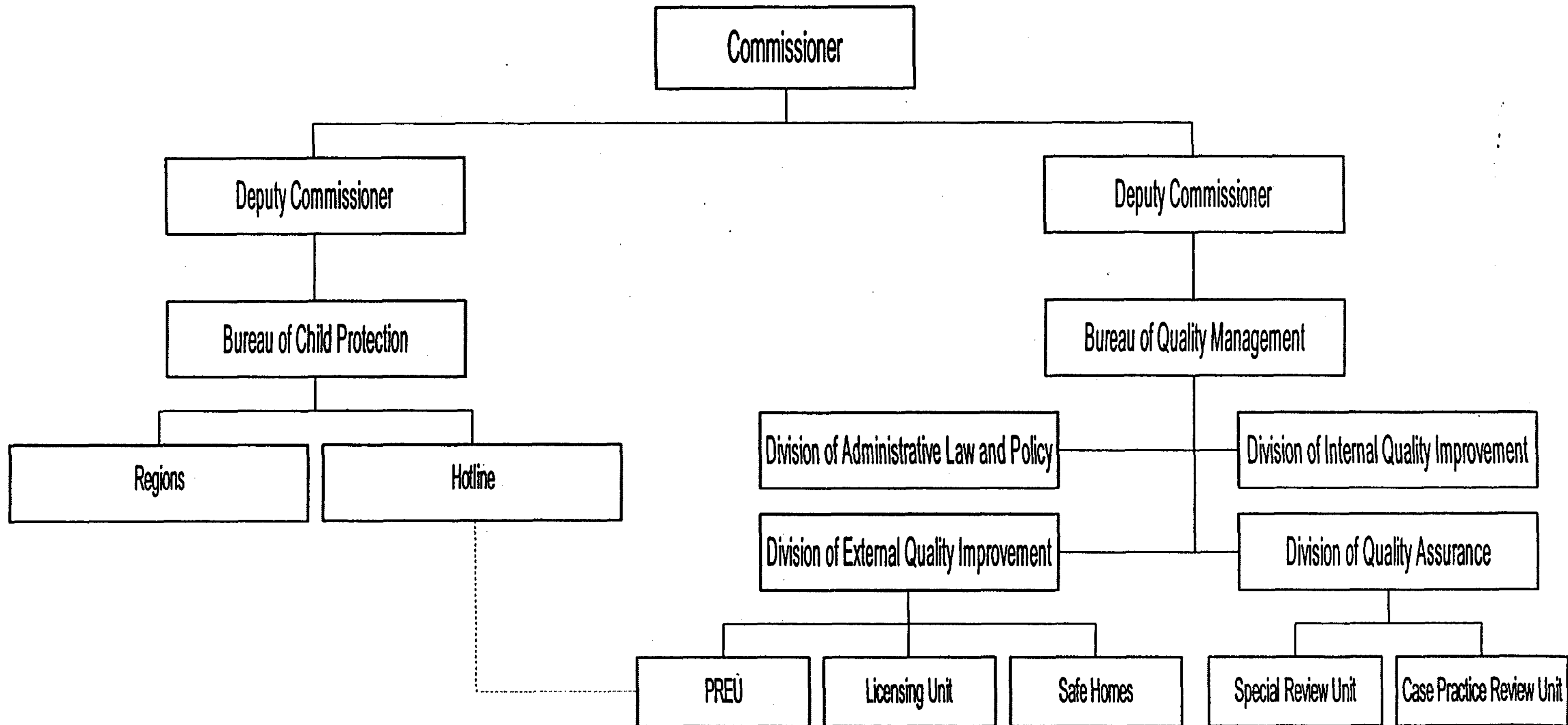
- Establish procedures to require an analysis of hotline reports and perform subsequent inspections as needed.

STATE AGENCY COMMENTS

The DCF officials stated its committment to improve the quality of care to Connecticut's children and has taken steps toward implementing our recommendations (See Appendix 2). These steps include: (1) developing and implementing a formal process to conduct quarterly visits for child care agencies, (2) hiring a an additional licensing inspector, (3) developing stringent regulations which will govern licensing actions and require the implementation of corrective action plans for deficiencies identified at child care agencies, (4) implementing a process to review hotline reports and perform subsequent inspections when warranted, and (5) developing procedures and guidelines for the consistent reporting of inspection activities and supervisory review of inspection reports. Further, DCF has closely supervised the corrective actions taken by Douglas House and YC and agrees that it must hold child care agencies accountable to provide the highest quality of care, and agencies must serve children with respect and dignity.

APPENDICES

Department of Children and Families
Organizational Chart
January 14, 2000



Department of Children and Families
Organizational Chart
January 14, 2000

Division of External Quality Improvement (EQI) - responsibilities are in the areas of provider licensing, program review and SAFE Homes program coordination. This Division is comprised of three units:

> **Licensing Unit** - This unit is responsible for the development of regulations, policies and procedures concerning licensees, and ensuring the integrity of DCF licensing and relicensing responsibilities by conducting direct licensing activities as well as monitoring regional licensing operations. Direct licensing responsibilities include childcare facilities, child placement agencies, extended day treatment, permanent family residences, and outpatient psychiatric clinics for children.

> **Program Review and Evaluation Unit (PREU)** – This unit is responsible for conducting studies of any program, service or facility developed, operated, contracted for or supported by DCF in order to evaluate its effectiveness. To accomplished this, the unit provides services in monitoring and evaluation, focused program review, program enhancement and consultation, and technical assistance.

> **SAFE Homes Coordinator** – The SAFE Homes coordinator's responsibilities include statewide coordination of the SAFE homes initiative, oversight on the standardization of contracts with providers, collection and analysis of data, quarterly reporting of outcome measurements, assistance in licensing or relicensing of safe home facilities.

The Division of Quality Assurance (QA) – responsibilities include coordinating implementation of the DCF IMPROVE Plan, reviewing implementation of recommendations from case practice reviews, and conducting special reviews. This Division is comprised of two units:

> **Case Practice Review Unit** - This unit is responsible for review of corrective action taken as a result of Administrative Case Review performed by the Administrative Case Review and Treatment Planning Unit within the Division of Internal Quality Improvement.

> **Special Review Unit (SRU)** – This unit's responsibilities include conducting timely internal case reviews of child fatalities in DCF cases, other cases at the request of the Commissioner, and coordinating investigations of abuse and neglect involving DCF employees.

The Division of Internal Quality Improvement - responsible for reviewing the cases of children in and out of home care who are in the custody of DCF. These reviews are to be conducted within the mandates of Federal law as legislated under the Child Welfare and Adoption Act of 1980 and in the Adoption and Safe Families Act of 1997, and related regulations.

The Division of Administrative Law and Policy (ALP) - responsibilities include enacting regulations required by federal and state law, developing and distributing DCF policy manual, providing administrative hearings for persons aggrieved by DCF actions, and providing related information and support to central and regional office staff.

Hotline Unit - This unit is responsible for initiating and taking appropriate and timely action on all telephone calls or written information alleging that a child has been abused, neglected, or in danger of being abused, and other types of calls related to services for children. Hotline investigative reports are distributed to the DCF Regional Administrator, EQI/PREU, and Bureau of Child Protection.

DEPARTMENT
of CHILDREN
and FAMILIES

JOHN G. ROWLAND
Governor

KRISTINE D. RAGAGLIA, Esq.
Commissioner

Caring for Connecticut's Future

November 20, 2000

Michael J. Armstrong
Regional Inspector General for Audit Services
Office of Audit Services
Region I
John F. Kennedy Federal Building
Boston, MA 02203

Re: A-01-00-02504

Dear Mr. Armstrong,

Thank you for the opportunity to provide comments on the draft report entitled "Adequacy of State Procedures for the Oversight of Douglas House and Youth Continuum, Inc." The Department of Children and Families (DCF) has worked closely with the Office of the Inspector General, and remains committed to improving the quality of care delivered to Connecticut's children.

As the issues with Douglas House were first identified on November 10, 1999, DCF has already made substantial progress towards implementation of the recommendations you have provided. Specifically, the following actions have been taken:

- DCF's Licensing Unit has already developed and implemented a formal process to conduct quarterly visits for child caring agencies.
- DCF has approved an additional Licensing Inspector position, bringing the number of inspectors to seven.
- DCF has developed new regulations to govern child caring agencies, and has begun the process to formally promulgate these regulations. Included in these regulations are more stringent criteria regarding licensing actions, and more stringent requirements for providers to implement corrective action plans in response to identified deficiencies.
- DCF has already implemented a process whereby the Division of External Quality Improvement reviews Hotline reports to determine if subsequent inspections or follow-up is warranted.
- DCF has developed procedures and guidelines for the consistent reporting of inspection activities, and requires supervisory review of reports.

STATE OF CONNECTICUT
(860) 550-6300
505 Hudson Street • Hartford, Connecticut 06106-7107
E-Mail: commissioner.dcf@po.state.ct.us
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It is important to note that DCF conducted its own internal review of the systemic issues identified as part of the Douglas House investigation. Based on this review, DCF has already improved oversight and monitoring activities. DCF has also closely supervised the corrective actions taken by Douglas House and Youth Continuum, and has supported management, program and physical plant changes.

The Department of Children and Families appreciates the effort put forth by the Office of the Inspector General to identify strategies to improve the effectiveness of licensing activities. DCF must hold agencies accountable to provide the highest quality of care, and agencies must serve children with respect and dignity.

Thank you for working with the Department on this important matter.

Very truly yours,

Kristine D. Ragaglia, Esq.

KDR/gb

cc: Hugh Galligan, Regional Director, ACF
Stacey H. Gerber, Deputy Commissioner
Thomas P. Gilman, Deputy Commissioner
Gary M. Blau, Ph.D., Bureau Chief, Bureau of Quality Management