Report in Brief
Date: March 2018
Report No. A-09-16-01006

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL

Some Washington State Group-Care Facilities for Children in Foster Care Did Not Always Comply With State Health and Safety Requirements

Why OIG Did This Review

Congress has expressed concerns about the safety and well-being of children in foster care. These issues were highlighted in media reports that provided several examples of children who died while in foster care. Additionally, a recent series of OIG health and safety audits of State-monitored childcare facilities found that the majority of childcare providers in various States had instances of potentially hazardous conditions and noncompliance with State health and safety requirements, including criminal records check requirements.

Our objective was to determine whether Washington State's monitoring ensured that group care facilities complied with State licensing requirements related to the health and safety of children in foster care, as required by Title IV-E of the Social Security Act.

How OIG Did This Review

Of the 51 group care facilities in Washington State that were eligible to receive foster care Title IV-E funding at the time of our audit, we selected 20 group care facilities on the basis of various risk-based factors, including their locations, the number of children at each facility, and the children's ages. We conducted unannounced site visits from August 9 to September 15, 2016.

What OIG Found

Although Washington State performed the required onsite monitoring at all 20 of the group care facilities that we reviewed, this monitoring did not ensure that these facilities complied with State licensing requirements related to the health and safety of children in foster care, as required by Federal law. We determined that all 20 group care facilities did not comply with 1 or more State health and safety requirements. Specifically, these facilities did not comply with requirements related to medical safety (20 facilities); environmental, space, and equipment safety (18 facilities); background checks (16 facilities); food safety (11 facilities); and fire safety and emergency practices (7 facilities).

What OIG Recommends and Washington State Comments

We recommend that Washington State (1) ensure that all instances of noncompliance that we identified are documented and corrected, (2) conduct unannounced visits for health and safety reviews of group care facilities, (3) ensure that regional licensors perform and document a site inspection during each health and safety visit at a group care facility, (4) ensure that regional licensors and group care facilities have adequate training and guidance on the best practices for administering medications and maintaining related documentation, (5) provide regional licensors and group care facilities with adequate guidance and supervision regarding background check requirements, (6) ensure that the handbook *Minimum Licensing Requirements for Group Care Facilities* is updated with the latest background check requirements, and (7) consider requiring Federal Bureau of Investigation (FBI) fingerprint-based background checks for all group care facility employees, seeking additional legislative authority as needed.

Washington State concurred with all of our recommendations and provided information on actions that it had taken or planned to take to address our recommendations. For example, Washington State commented that it had updated its policy to require 10 percent of health and safety monitoring visits to be unannounced. Furthermore, it commented that it was going through the rulemaking process to require FBI fingerprint-based background checks for all group care facility employees and that it will update the handbook *Minimum Licensing Requirements for Group Care Facilities* to reflect this change.