The purpose of this memorandum is to share with you the results of our review of Health and Safety Standards at Child Care Facilities in the State of Wisconsin. A copy of the final report is attached.

The Office of Inspector General performed this review as part of a broader effort to assess risk to our Nation's children in child care facilities. Recognizing that the adequacy of facilities is a critical element for satisfactory delivery of services to children, we have initiated a series of reviews to assess whether providers of child care services are in compliance with appropriate Federal, State or local authorities' health and safety standards. Additionally, we assessed the State monitoring and oversight.

The review disclosed that additional attention is needed in the State of Wisconsin to improve the health and safety conditions as well as the recordkeeping at the facilities. The facilities visited receive Federal funding from the Social Services Block Grant for Day Care, Head Start, and the Foster Care programs.

Accompanied by State inspectors or a county licenser, we performed unannounced on-site inspections of 39 facilities (30 randomly selected, 9 judgmentally selected) with a licensed capacity to care for 819 children. We found 755 violations of State codes and areas where improvements can be made at the facilities visited. The violations ranged from discrepancies in employees' records such as missing character or personal reference checks and children's records medical records to fire code violations and unsanitary conditions. Examples of the types of health and safety hazards noted that placed the children "at risk" were food improperly stored, exposed light sockets; dangerous chemicals and firewood stacked against a woodburning stove.
The types of deficiencies noted at the State of Wisconsin parallel those previously reported for the States of Delaware, Virginia Pennsylvania (A-03-91-00550); North Carolina (A-12-92-00044) Native American Head Start facilities participating in the Native American program (A-09-91-00134).

The results of our reviews reinforce the findings recently reported by the General Accounting Office (GAO) in its report entitled, "CHILD CARE: States Face Difficulties Enforcing Standards and Promoting Quality." The GAO reported that many States face difficulties protecting children from care that does not meet minimum safety and health standards. In particular, staffing and budget cuts in several States have reduced on-site monitoring, a key oversight activity that is necessary for the enforcement of standards.

We believe the results of our efforts will provide you with additional insight to the level of compliance by the State with existing child care standards. Additionally, this report may be helpful to you in providing internal oversight of grants to States and community nonprofit organizations to provide child care services from the various Administration for Children and Families programs.

The State of Wisconsin in response to our draft audit report, acknowledged that there were numerous deficiencies at the child care facilities we visited. The response which is appended to the final report, lists several steps taken by the State to strengthen its licensing process.

We are recommending that the State of Wisconsin continue its efforts to take additional steps to strengthen compliance with health and safety standards.

If you have any questions, please call me or have your staff contact John A. Ferris, 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

REVIEW OF HEALTH AND SAFETY STANDARDS AT CHILD CARE FACILITIES IN WISCONSIN
Mr. Gerald Whitburn, Secretary
Department of Health and Social Services
1 West Wilson Street
Madison, Wisconsin 53703

Dear Mr. Whitburn:

Enclosed for your information and use are two copies of an Office of Inspector General audit report titled "Review of Health and Safety Standards at Child Care Facilities in Wisconsin."

Final determination as to actions to be taken on all matters reported will be made by the HHS action official. We request that you respond to the HHS 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. It should be directed to: Regional Administrator, Administration for Children and Families, Region V, 105 West Adams Street, 20th Floor, Chicago, Illinois 60603.

In accordance with the principles of the Freedom of Information Act (Public Law 90-23), Office of Inspector General audit reports issued to the Department's grantees and contractors are made 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 cite Common Identification Number A-05-92-00103 in all correspondence relating to this report.

Sincerely,

Martin D. Stanton
Regional Inspector General for Audit Services

cc: Ms. Marion Steffy, ACF
SUMMARY

During recent years, the Federal Government has expanded its role in placing greater emphasis on the needs of America's children and families. Within the Department of Health and Human Services, the Administration for Children and Families (ACF) administers various grants to states and community non-profit organizations to provide child care and alternative care services, Head Start programs, and financial assistance to low-income families.

The Federal Government relies on the States to ensure that child care programs meet health and safety standards. Accordingly, the primary responsibility for assuring quality of care and for developing and enforcing regulations that protect the health and safety of children in child care facilities rests with State and local governments. States can improve the quality of care by regulating child care providers, establishing standards that approved providers must meet and by monitoring providers for compliance with the standards.

Our review at 39 child care facilities in Wisconsin disclosed instances where State standards were not always being followed. Some examples are: fire code violations, such as fire inspections and fire drills not always performed; unsanitary conditions, such as food improperly stored and mildew in bathrooms; and facility hazards, such as firewood stored next to a woodburning stove and light bulbs missing from light sockets. We also found that employee reference checks were not always performed and that children did not always receive the required health and dental examinations. Based on our observations, we believe that more frequent visits to child care facilities by State licensing inspectors could help reduce the risk of exposure to health and safety hazards.

Accompanied by State inspectors, we performed unannounced on-site inspections of 30 randomly selected foster care facilities with a licensed capacity to care for a total of 588 children. Using the State's checklist at the 30 facilities, we found the following violations:

<table>
<thead>
<tr>
<th>Deficiency</th>
<th>Occurrences</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fire code violations</td>
<td>20</td>
</tr>
<tr>
<td>Unsanitary conditions</td>
<td>57</td>
</tr>
<tr>
<td>Unprotected toxic chemicals</td>
<td>1</td>
</tr>
<tr>
<td>Facility hazards</td>
<td>157</td>
</tr>
<tr>
<td>Incomplete employee records</td>
<td>259</td>
</tr>
<tr>
<td>Incomplete children's records</td>
<td>113</td>
</tr>
<tr>
<td>Nutrition</td>
<td>5</td>
</tr>
<tr>
<td>Total</td>
<td>612</td>
</tr>
</tbody>
</table>
We also performed unannounced inspections at 9 judgmentally selected facilities with a licensed capacity to care for 231 children. These facilities were selected because of their record of prior deficiencies and proximity to the randomly selected facilities. Eight of the 9 facilities had violations which are summarized as follows:

<table>
<thead>
<tr>
<th>Deficiency</th>
<th>Occurrences</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fire code violations</td>
<td>17</td>
</tr>
<tr>
<td>Unsanitary conditions</td>
<td>41</td>
</tr>
<tr>
<td>Unprotected toxic chemicals</td>
<td>4</td>
</tr>
<tr>
<td>Facility hazards</td>
<td>76</td>
</tr>
<tr>
<td>Incomplete children's records</td>
<td>4</td>
</tr>
<tr>
<td>Nutrition</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>143</strong></td>
</tr>
</tbody>
</table>

Children receiving care at 38 of the 39 facilities we inspected were, to varying degrees, at risk of exposure to health and safety hazards. Some of the deficiencies, such as missing smoke detectors, a locked fire exit door, missing light bulbs from light sockets, and toxic chemicals which were readily accessible to the children in at least one of the facilities, were of a serious nature. Most of the other deficiencies such as missing window screens and broken towel racks were not as serious, but collectively, present a significant health and safety hazard.

We also found that some facilities did not require their employees to obtain physical examinations and tuberculin tests, or that employee physicals were not scheduled until after the individual was employed. Pre-employment physicals and tuberculin tests are important in safeguarding the health of the children. Our inspections also showed that documentation was not always available to determine whether: (i) employees had received in-service and first aid training, (ii) character and prior employment references had been contacted, and (iii) criminal history checks had been made. Adequate training is necessary to keep staff abreast of the latest developments in the child care field and to help staff deal with medical emergencies that may arise. Reference and criminal history checks are necessary to provide assurances that all staff are qualified and that the safety of the children is not jeopardized.

In reviewing children's files, we found many instances where physical and dental examinations and immunizations were not performed or, if performed, were not documented. These preventive services are necessary for the health of the children and should be performed and documented in the files.

In our opinion, more frequent visits by State licensing inspectors (licensers) to improve compliance, and the authority to impose sanctions for noncompliance, could reduce the number of health and safety violations at child care facilities.
In a written response to our draft audit report, the State acknowledged that there were numerous deficiencies at the child care facilities we visited. The response, which is appended to this report, lists several steps taken by the State to strengthen its licensing process.
TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Summary</td>
<td>1</td>
</tr>
<tr>
<td>Introduction</td>
<td>1</td>
</tr>
<tr>
<td>Background</td>
<td>1</td>
</tr>
<tr>
<td>Scope</td>
<td>2</td>
</tr>
<tr>
<td>Results of Review</td>
<td>3</td>
</tr>
<tr>
<td>Randomly Selected Facilities</td>
<td>4</td>
</tr>
<tr>
<td>Judgementally Selected Facilities</td>
<td>8</td>
</tr>
<tr>
<td>Conclusions and Recommendations</td>
<td>10</td>
</tr>
<tr>
<td>State Agency Comments and OIG Response</td>
<td>11</td>
</tr>
<tr>
<td>Attachment - State Agency Response to Draft Audit Report</td>
<td>13</td>
</tr>
<tr>
<td>Exhibit - Photographs Taken at Selected Facilities</td>
<td></td>
</tr>
</tbody>
</table>
INTRODUCTION

Recognizing that the adequacy of facilities is a critical element for satisfactory delivery of services to children, the Office of the Inspector General (OIG) has initiated a series of reviews to assess whether providers of child care services are in substantial compliance with applicable Federal, State and local health and safety standards. The primary focus has been directed towards grantees and child care facilities which receive funding from three major Administration for Children and Families (ACF) programs:

- Foster Care
- Social Services Block Grant (Day Care)
- Head Start

For Foster Care and Day Care programs, the States are responsible for ensuring that the facilities meet State and local health and safety requirements. Head Start facilities must have evidence that the facility meets or exceeds State and local licensing requirements for fire, health and safety.

Our review in Wisconsin focused primarily on the 30 Foster Care facilities which we randomly selected and, to a lesser extent, on 9 additional Day Care and Head Start facilities that were judgmentally selected. The review included an evaluation of the licensing and inspection procedures for facilities that received funding under these Programs.

BACKGROUND

Foster Care

For Foster Care facilities in Wisconsin, licensors perform inspections at the larger facilities (4 or more children). The licensors are in the State's Bureau of Program Quality Assurance, Regulation and Licensing, which is a part of the Division of Community Service, Department of Health and Social Services. For the smaller facilities (less than 4 children), county personnel perform licensing inspections using State checklists.

The Adoption Assistance and Child Welfare Act of 1980 (Public Law 96-272) established the Title IV-E Foster Care Program. Foster care may be provided to children in group homes, agency operated boarding homes or other facilities licensed or approved by the State agency. Title 45 of the Code of Federal Regulations (CFR), Parts 1355, 1356, and 1357, sets forth general requirements for Federal financial participation under Titles IV-E and IV-B of the Social Security Act, as amended. Part 1356.20 of the CFR states that to be eligible for Federal financial participation, the State must have a plan approved by the Secretary that meets the requirements of Section 471 of the Social Security Act.

Section 471(a) of the Social Security Act requires that a State authority be responsible for establishing and maintaining
standards for foster family homes and child care institutions receiving funds under Titles IV-E and IV-B. These standards should reasonably be in accord with recommended standards of national organizations concerned with standards for such institutions or homes, including standards related to admission policies, safety, sanitation and protection of civil rights.

In Wisconsin, compliance with the standards is achieved through inspections of foster care facilities by licensors. For licensing purposes, the State has identified three types of facilities: (i) child care institutions (CCI), (ii) foster care group homes, and (iii) family foster care homes. The following is a brief description of each of the three types of facilities:

A CCI is a child welfare agency licensed to provide care and maintenance for nine or more children.

A group home is licensed to provide 24-hour care for up to eight children. The smallest facility, a family foster care home, is licensed to provide care and maintenance for up to four children.

**Day Care**

The ACF funds day care through the Title XX Social Services Block Grant. The day care services are provided in three types of settings: (i) certified day care centers, (ii) family day care, and (iii) group day care. States have the primary responsibility for establishing and enforcing health and safety standards and regulations regarding day care.

According to 45 CFR, Part 255.5, the State IV-A agency is required to establish procedures to ensure that day care facilities meet State and local standards. The standards must be sufficient to ensure basic health and safety (including fire safety) protection to the children that reside in the facilities.

**Head Start**

Title V of the Economic Opportunity Act of 1964 authorized the Head Start Program. Head Start facilities are governed by the standards of 45 CFR, Subpart B, Section 1304.2-3. These standards require that space, light, ventilation, heat, and other physical arrangements at the facilities be consistent with the health, safety and developmental needs of the children. In addition, the performance standards require evidence that the child care facilities meet or exceed State or local health and safety requirements for similar kinds of facilities.

The Head Start program is administered by the ACF. Grants are awarded by the ACF Regional Offices to local public and private non-profit organizations and agencies for the purpose of operating Head Start programs at the community level.
SCOPE

Our review was conducted in accordance with generally accepted government auditing standards. The purpose of our review was to determine whether providers of child care services were in compliance with applicable Federal, State and local health and safety standards.

We evaluated the internal controls, including licensing requirements, standardized checklists and on-site inspection procedures, used by the State to ensure that child care facilities are in compliance with health and safety standards. In addition, we assessed the State's oversight efforts and monitoring of the child care facilities. We also reviewed the State's requirements for background checks on child care employees.

Our review was designed to identify areas where improvements could be made in health and safety conditions at child care facilities. The areas reviewed included:

- Federal, State and local requirements for health and safety at child care facilities.
- Degree of compliance with the health and safety requirements by providers at 30 randomly selected foster care facilities, and at 9 judgmentally selected foster care, day care and Head Start facilities.

The universe from which our sample was selected was comprised of those facilities which received Title IV-E payments in December 1991. We determined that there were 74 foster care facilities which met our selection criteria. We randomly selected 30 of the facilities for review, including 21 group homes and 9 CCIs. The additional 9 judgmentally (non-random) selected facilities were chosen because of their proximity to the randomly selected facilities and record of previous violations.

The review was accomplished using an audit guide developed by the HHS/OIG and the State's licensing checklists. The review included the following procedures:

- Contacting the State agency to obtain background information and to determine the responsibilities for licensing and monitoring child care facilities.
- Selecting a random sample of 30 foster care facilities and identifying 9 other facilities to visit and review their documentation supporting compliance with health and safety requirements.
- Performing unannounced visits to the facilities to conduct inspections related to compliance with health and safety requirements and to review their recordkeeping practices for children and employees.
RESULTS OF REVIEW

Our visits to 39 child care facilities in Wisconsin disclosed a need for the State to take additional steps to improve compliance with its health and safety standards. We found violations of State licensing standards at 38 of the facilities. We believe that additional controls and safeguards are needed to assure compliance with standards that were established to protect the health and safety of children in child care facilities.

We identified a number of deficiencies that were relatively serious. In many cases, these violations could be easily corrected by the facility. Most of the other deficiencies we observed were not as serious but, collectively, present a significant safety hazard to the children.

We believe that the State could take certain steps to reduce the relatively high number of environmental health and safety hazards and administrative deficiencies at child care facilities. Our inspections at these facilities disclosed that requirements relating to health and safety were not always met.

REVIEW OF RANDOMLY SELECTED FACILITIES

Accompanied by State licensors, we found a total of 612 individual health and safety deficiencies at the 30 foster care facilities, categorized as follows:

HEALTH AND SAFETY FINDINGS

<table>
<thead>
<tr>
<th>Category of Finding</th>
<th>Number of Facilities</th>
<th>Number of Occurrences</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fire code violations</td>
<td>9</td>
<td>20</td>
</tr>
<tr>
<td>Unsanitary conditions</td>
<td>18</td>
<td>57</td>
</tr>
<tr>
<td>Toxic chemicals in an unlocked storage area</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Nutrition-menus</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Facility hazards</td>
<td>22</td>
<td>157</td>
</tr>
<tr>
<td>Employee records</td>
<td>24</td>
<td>259</td>
</tr>
<tr>
<td>Children's records</td>
<td>21</td>
<td>113</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>612</strong></td>
<td></td>
</tr>
</tbody>
</table>

For most categories, more than one health and safety deficiency was observed at a facility.
The State licensers had identified 210 violations during their most recent prior visit to each of the 30 facilities. The difference in the total number of deficiencies found in our review (612) and the number found by State licensers in their prior visits (210) is attributable primarily to the manner in which we counted the deficiencies. For example, if a facility had five incomplete children's records we counted five deficiencies, whereas State licensers counted this as one deficiency.

We found 62 repeat violations during our site visits. The State usually works closely with facilities that have deficiencies to help bring them into compliance with health and safety requirements and performs follow-up visits to determine whether the facilities have corrected the deficiencies. The deficiencies noted during our site visits are summarized as follows:

1. **Fire Code Violations**

   Twenty fire code violations were found at 9 of the facilities visited. Violations included a locked fire exit door (1), fire drill not conducted (1), missing smoke detectors (7), firewood improperly stored including one instance of wood stacked next to a woodburning stove (3), emergency evacuation plan not posted in the home (2), and fire extinguishers not inspected on a timely basis (6).

2. **Unsanitary Conditions**

   Fifty-seven unsanitary conditions were noted at 18 of the facilities. These included bed linens not changed on a weekly basis (1), food improperly stored (20), full and uncovered trash containers (12), dirty dishes piled in sinks (4), messy and dirty resident rooms (8) and instances of mildew in shower stalls and bathtub enclosures (12).

3. **Toxic Chemicals**

   We noted one instance of a toxic material (chemical stripper) stored in an unlocked closet, which made it accessible to the children.

4. **Nutrition**

   We found five instances in which menus were not prepared. Menus are important because they provide a record that the meals served met the children's nutritional needs.

5. **Other Facility Hazards**

   Included in the 157 hazards were light bulbs missing in light sockets (7), broken glass pane in a kitchen cupboard (1), window screens missing or torn (8), water too hot (4), non-slip safety strips missing from bathtubs (3),
and bathrooms without windows or exhaust ventilation (3). The remaining 131 included deficiencies such as worn or torn carpet, water damaged ceilings and walls needing paint.

6. **Employee Records**

We reviewed 167 employee records and found 259 incomplete or missing items. The deficiencies included missing character or personal reference checks (60), in-service and first-aid training not documented (98), physical examinations not obtained (69), missing tuberculin tests (12), and job descriptions missing from files (20).

7. **Children's Records**

We reviewed 158 children's records and found 113 incomplete or missing items. Physical or dental examinations had not been performed or were not current (81), immunization records were missing (31) and, in one case, confinement time and reasons were not documented (1). (Confinement involves placing a child in an isolated room under observation, usually because of a behavioral problem.)

Our observations were discussed with the State licensors who accompanied us on our inspections. They agreed with our findings.

**Background Checks**

We found that the State of Wisconsin does not have a formal policy requiring that the facilities arrange to have criminal background checks performed of prospective employees. We did note, however, that the State has sent policy guidance to its five regional offices suggesting that criminal background checks be done. In addition, the State's proposed draft of changes to its CCF policy requires that criminal background checks be performed. We noted that only a few of the facilities had requested background checks from local police jurisdictions, and that most checks were not done until after the employee had started work.

Because Wisconsin does not have a formal policy for requiring background checks and does not have a child abuse registry, children in child care facilities may be at risk. Background checks help ensure that prospective employees with a history of child abuse are not employed in child care facilities. The checks can determine whether they have a criminal record or a history of child abuse or neglect. Without these checks, individuals who should be barred from working with children may be working in child care facilities.

**Workload**

Licensors are responsible for the licensing of foster care facilities which is based, in part, on an inspection of the
facility. State regulations provide for announced inspections for renewal of a license, for routine unannounced inspections to ensure compliance, and for additional inspections in response to complaints.

As of February 1993, Wisconsin had licensed 122 group homes and 40 CCIs. The State is divided into five regions and is staffed by 49 licensers (full-time equivalents) as follows:

<table>
<thead>
<tr>
<th>Region</th>
<th>No. of Licensors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Southern - Madison</td>
<td>12.0</td>
</tr>
<tr>
<td>Northern</td>
<td>5.5</td>
</tr>
<tr>
<td>Milwaukee/Southeastern</td>
<td>13.5</td>
</tr>
<tr>
<td>Eastern</td>
<td>10.0</td>
</tr>
<tr>
<td>Western</td>
<td>8.0</td>
</tr>
<tr>
<td>Total</td>
<td>49.0</td>
</tr>
</tbody>
</table>

There were no State licensers specifically assigned to inspect only group homes or CCIs. The workload of each licenser, which generally ranged between 110 and 120 cases, also included shelter care, adult day care, group day care, family day care, community based residential facilities and child placing agencies. A State official told us that the State licensed an additional 500 day care centers in 1993. This will add about 10 cases to each of the licenser's workload. In order to keep up with the increased workload, the State has hired an additional 17 licensers since 1989 and has requested funding for 5 more licensers.

Because of the different factors involved in a site visit such as the level of experience of the licenser, and whether the visit is for licensing, monitoring or a complaint, the State does not allocate a set amount of time for the licenser to perform a visit. We did not perform a workload analysis, but we interviewed several licensers regarding their workload. For the most part, they thought the available time to conduct their reviews was adequate.

State policy requires that a facility be inspected before its license expires. Licenses for CCIs and group homes are normally in effect for two years. However, a license is considered to be in-force until a visit is made, even if the visit is after the expiration date. None of the facilities that we inspected had a license in effect beyond its expiration date.

**LICENSING INSPECTIONS**

The State requires that an on-site study be conducted at a child care facility prior to initial licensure. At least one site visit must be made to the facility before a license is issued. A provisional license is issued to a new facility which cannot immediately meet a required compliance item, such as required fencing that cannot be installed because of frozen ground. The State may also issue a six-month provisional license, which can
be extended for up to two years to allow a facility to correct deficiencies.

An announced site visit is performed prior to relicensing. This visit consists of a full compliance inspection including a sampling of records.

State policy provides that all licensed facilities receive at least one annual unannounced monitoring visit. This visit, while less comprehensive than the announced visit, includes verification that non-compliance items cited in the previous visit have been corrected.

The State requires licensors to investigate, within five working days, any complaint regarding a child care facility which implies an immediate or potentially serious threat. Investigations of less serious complaints are to be started within 10 working days.

The Wisconsin DHSS Division of Community Services has standardized its checklists for conducting annual licensing inspections of foster care facilities. They have separate checklists for each type of foster care home and day care facility. These checklists, which cover applicable health and safety standards, are based on Wisconsin State Statutes and are consistently followed by the State licensors.

Currently, the State cannot impose fines or penalties on the child care facilities for non-compliance. However, we were told that proposed legislation would allow the State to impose fines or penalties on facilities which are not in compliance with State child care regulations.

REVIEW OF JUDGMENTALLY SELECTED FACILITIES

We made unannounced visits to nine judgmentally selected facilities and, using the State's checklist, found 143 individual health and safety violations. During these visits, we were accompanied by a State or a county licensor. The facilities that we visited were identified by State officials and were chosen because of their history of problems and their proximity to the facilities we statistically selected. Due to the judgmental selection of these facilities, the results cannot, and should not, be used to make any statistical inference about the condition of child care facilities statewide.

We visited four Group Day Care facilities (two were licensed as Head Start facilities), two Family Day Care facilities, two Family Foster Care facilities, and one Group Foster Care facility. A Family Day Care Center is a facility licensed to provide care to from four through eight children. A Group Day Care Center is a facility licensed to provide care for nine or more children.

The deficiencies we noted at the 9 judgmentally selected facilities are summarized as follows:
HEALTH AND SAFETY FINDINGS

<table>
<thead>
<tr>
<th>Category of Finding</th>
<th>Number of Facilities</th>
<th>Number of Occurrences</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fire code violations</td>
<td>7</td>
<td>17</td>
</tr>
<tr>
<td>Unsanitary conditions</td>
<td>7</td>
<td>41</td>
</tr>
<tr>
<td>Toxic chemicals in an unlocked storage area</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Playground hazards</td>
<td>2</td>
<td>18</td>
</tr>
<tr>
<td>Facility hazards</td>
<td>8</td>
<td>58</td>
</tr>
<tr>
<td>Children's records</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Nutrition-menus</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>143</strong></td>
<td></td>
</tr>
</tbody>
</table>

For most categories, more than one health and safety deficiency was observed at a facility.

The deficiencies noted were as follows:

1. **Fire Code Violations**
   
   Seventeen fire code violations were found at 7 facilities. Violations included smoke detectors with a missing battery (5), partially obstructed fire exit passageways (7), and fire alarm systems and extinguishers not tested or inspected on a regular basis (5).

2. **Unsanitary Conditions**
   
   Forty-one unsanitary conditions were noted. These included a paper bag with food in it serving as a garbage container (1), filthy kitchen sinks (3), children sleeping on cots that did not meet sanitation requirements such as not being separated by the required 2 feet (4), food stored in refrigerators at improper temperatures and past the recommended use dates (7), open garbage cans (10), peeling paint and linoleum not sealed along walls (5), and torn and improperly sized screens on windows (2), and other deficiencies (9).
3. **Toxic Chemicals**

Four instances of deficiencies relating to toxic chemicals were noted. These included prescription medications sitting on a counter top (1), cleaning materials and disinfectants stored in unlocked cabinets within reach of small children (3).

4. **Playground Hazards**

Eighteen playground hazards were found at 2 of the facilities. Violations included a metal grate for hot water heat that was extremely hot (steam was rising from the grate) located under playground equipment (1), loose debris in yards, (i.e., sharp sticks, rocks, plastic bags and bricks) (9), spaces measuring up to 10 inches between railings on a picket fence that a small child could crawl through and wander onto the street (2), an entry door with a glass panel leaning against the home (1) and other potential hazards (5).

5. **Facility Hazards**

Fifty-eight other facility hazards were observed. These included steam radiators not protected by screens (6), uncovered light fixtures (4), uncovered electrical outlets (18), pointed scissors lying on the kitchen counter within reach of small children (2), large kitchen knives in drawers which could be opened by small children (4), sharp metal edges on a storm door (3), and other hazards (21).

6. **Children's Records**

Four children's records at two facilities did not contain medical and immunization histories.

7. **Nutrition**

One facility did not prepare menus. Menus should be prepared because they provide a record that planned, nutritious meals were served.

**CONCLUSIONS AND RECOMMENDATIONS**

Some of the health and safety deficiencies that we identified such as a locked fire exit door, missing or inoperative smoke detectors, and toxic substances within easy reach of the children pose a definite threat to the children. Other deficiencies such as a lack of employee background and employment reference checks, while not quite as obvious, also place the children at a greater risk. Most of the other deficiencies, for example, broken furniture and fixtures, uncovered trash cans and dirty facilities, also present potential health hazards. The Exhibit to this report contains photographs that were selected to
illustrate some of the health and safety violations observed during our visits to child care facilities.

In our opinion, the risk of exposure to health and safety hazards could be reduced if the State were to take additional steps to strengthen compliance with health and safety requirements.

We noted that the State has acted to attain better compliance with the standards. For example, beginning in 1989, 17 more licensers were hired for a total of 49, and funding has been requested for 5 more licensers. To make the licensing process more effective, the licensers' workloads were concentrated on fewer types of facilities. In addition, legislation was introduced to allow the State to penalize facilities which are not in compliance with the standards. In our opinion, these actions should help the State achieve greater compliance with its standards.

More frequent compliance visits on the part of State licensing inspectors and the authority to fine or impose sanctions for noncompliance with State health and safety requirements could help reduce the relatively large number of deficiencies. The licensers who accompanied us on our inspections stated that although they generally had enough time to make the required reviews, they could probably be more effective if they were able to perform more frequent visits. One State representative said that quarterly site visits to the facilities would be more appropriate than annual visits.

The State of Wisconsin should consider making more frequent visits to improve compliance with State regulations by the child care facilities. The State should take steps to improve the facilities compliance with:

- Fire and building codes by strictly enforcing fire and other building regulations;
- Sanitation regulations by requiring inspectors to strictly enforce sanitation requirements;
- Requirements for completing background checks on child care providers to assure that the intent of current regulations is upheld, and;
- Requirements for obtaining medical and dental examinations for the children.

STATE AGENCY COMMENTS AND OIG RESPONSE

In a written response dated June 14, 1993, the State agency acknowledged that there were numerous deficiencies at the child care facilities we visited, and that some of the violations were serious. Their remaining comments address the auditor's presentation of the audit findings and recommendations. The State's response is included as an Appendix to this report.
The State expressed a concern that the draft report implies that State licensers were not diligent because the report contrasts the 612 health and safety deficiencies found by the auditors with the 210 violations found by State licensers during their previous visits to the same facilities. We believe that the State licensers were diligent in their inspections. We have clarified page 5 of this report to explain that the difference is attributable to the different methods used by the licensers and the auditors in counting the deficiencies.

The State suggested that the audit report more clearly describe how the "judgmentally selected facilities" were selected. We have clarified the Summary and Introduction of this report to describe our basis for selecting those facilities.

Relative to our audit recommendation that the State take steps to improve the facilities' compliance with licensing standards, the State's response lists five additional actions that it has taken to strengthen its licensing process for child care facilities.

An exit conference with the State agency was held on June 18, 1993.
STATE AGENCY RESPONSE
TO DRAFT AUDIT REPORT
June 14, 1993

Mr. Leon Siverhus, Senior Auditor
DHHS/OIG/Office of Audit Services
St. Paul Field Office
Farm Credit Services Building
375 Jackson Street, Suite 310
St. Paul, Minnesota 55101

Dear Mr. Siverhus:

I am writing in response to your request for comment on your draft report entitled "Review of Health and Safety Standards at Child Care Facilities in Wisconsin." Our Department's response deals with two areas: 1. the presentation of the facts, and 2. the reasonableness of the recommendations.

1. The presentation of the facts.

First, we recognize that there were numerous deficiencies found in the child care facilities you visited, and that some violations were serious. While we recognize what your auditors observed, we have concerns with the way the information is presented.

We believe it is misleading to refer to 612 health and safety deficiencies in the randomly selected facilities. Of these deficiencies, 372 are related to child and staff records and 139 have to do with non-hazardous physical plant maintenance problems. Thus, over 83% had to do with records or maintenance. Although some of these may present health or safety concerns, we believe that counting each deficiency individually could suggest that all violations are of equal validity. The report's method of counting deficiencies inflates the numbers to levels which appear more alarming than necessary. The report cited as a deficiency each instance in a file, and then contrasts the number of deficiencies the auditors found with the 210 violations our licensers uncovered on our most recent visits. The implication is that we were not diligent. However, we normally cite a facility once for incomplete staff records and once for incomplete child records; we don't cite individually for every problem in every file.

Secondly, the report refers in the report to "judgmentally selected facilities." The term "judgmentally selected" does not describe clearly how these facilities were
selected. Auditors asked us to identify programs with a history of serious violations. We did so. It of course came as no surprise to us that numerous violations were found, since we had serious concerns about several of these facilities, and some are now no longer operating due to our enforcement actions. We believe the report should be clearer in the summary and introduction about the selection of the 9 facilities.

2. Reasonableness of the recommendations.

Auditor’s Note: This portion of the State’s response has been deleted based on changes to the report agreed to at the exit conference.

There are five developments in Wisconsin licensing which we believe are worth noting, in addition to what you have mentioned:

1. In 1991 the Department centralized statewide child care facility licensing efforts by creating an Office of Regulation and Licensing to oversee field operations. The Office has worked hard to provide training for licensing staff, to increase the consistency of rule interpretation, and to revise existing rules.

2. The Office of Regulation and Licensing has increased the number of unannounced visits to facilities. Policies require at least one unannounced visit annually to each facility (more if serious violations exist). Licensors are making shorter, more frequent unannounced visits to facilities.

3. More visits are made to facilities with a history of serious violations. Policies require licensing staff to assign a monitoring plan to each facility, based on the history of compliance (or non-compliance) with rules. We have also developed and implemented an automated licensing activity tracking system, which helps us monitor site visits to programs according to the monitoring plan assigned.

4. Specialization of licensing has increased, with licensors concentrating on fewer types of facilities. For instance, in 1991 12 licensors monitored child care institutions (CCIs) as well as other facilities; today only 5 staff monitor CCIs and
their overall workloads have reduced, enabling them to spend more time concentrating on the CCIs. With reduced numbers of licensors involved and specializing on CCI licensure, it has been easier for us to provide extensive training to increase their expertise and the consistency of their application of rules.

5. The Department is finalizing extensive licensing rule changes for child care institutions and group day care centers to increase the protections for children. The rules are scheduled to be promulgated by mid-1994.

Wisconsin has been strengthening its licensing program over the last 4-5 years, while many states have had to cut back on licensing resources and attention. We believe it is appropriate for your report to reflect the extensive efforts in Wisconsin to improve protections for children in out-of-home care through a strong licensing program.

Finally, your report calls for more licensing visits, implying the need for additional licensing staff. Given our efforts to increase the number of shorter, unannounced visits to facilities, the only feasible way for us to increase the number of visits is to increase staff positions. We are unclear what standard is being applied here. Wisconsin developed a licensing workload formula in 1989, and has made great efforts since then to meet the workload standards, adding 17 licensers and proposing 5 more in the 1993-95 State Budget. While more licensing visits (perhaps even quarterly visits) to all facilities may be desirable, as implied in your report, we doubt that many states can afford this level of licensing or that taxpayers are willing to pay for this level of regulation. If your report is to suggest the need for for additional licensing staff, we believe that recommendation should be based on some standard or state-by-state comparison. We would also welcome any Federal financial assistance to enable us to improve our licensing operation.

Thank you for this opportunity to respond to your draft report. Our Department has appreciated the courtesy shown to our staff throughout the auditing process. Do not hesitate to contact David Edie at 608-266-6946 if you have further questions or concerns.

Sincerely,

Richard W. Lorang
Deputy Secretary
REVIEW OF HEALTH AND SAFETY STANDARDS AT CHILD CARE FACILITIES IN WISCONSIN

PHOTOGRAPHS TAKEN IN SELECTED CHILD CARE FACILITIES

NOTE: The photographs in this report were selected to illustrate some of the health and safety violations observed during our visits to child care facilities. They are not intended to be representative of conditions in all of the facilities.
Firewood stacked against a woodburning stove creates a potentially dangerous condition. (Fire Hazard)

Loft railing is not adequate to prevent children from falling to a lower level. (Facility Hazard)
Toxic substances stored in an unlocked area are easily accessible to children. (Toxic Chemicals)

Broken deadbolt lock does not allow door to be opened in an emergency. (Fire Hazard)
Fire exit route is nearly impassable because of cluttered passageway.  
(Fire Hazard)

Broken sheetrock in hallway allows access to electrical wiring.  
(Facility Hazard)
Exposed light socket is accessible to the children.
(Facility Hazard)

Lamp without shade could cause injury or fire.
(Facility Hazard)
Dirty oven. (Unsanitary Condition)

Food stored in an area that is being remodeled. (Unsanitary Condition)