# Arizona Department of Child Safety
## Licensed Foster Care Provider Oversight

Department problems related to investigating, taking enforcement action against, and monitoring licensed out-of-home care providers could result in risky or unhealthy environments for children in out-of-home care

Performance Audit

September 2023
Report 23-113

A Report to the Arizona Legislature

**Lindsey A. Perry**
Auditor General

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## Audit Staff

**Jeff Gove**, Director
**Kaylee Arteaga**, Visual Communications Specialist

**Tanner Weigel**, Team Leader
**Otto Brink**
**Dorothy Henry**

## Contact Information

**Arizona Auditor General**
**2910 N. 44th St., Ste. 410**
**Phoenix, AZ 85018-7271**

**(602) 553-0333**

**contact@azauditor.gov**

**www.azauditor.gov**

**LINDSEY A. PERRY**
AUDITOR GENERAL

ARIZONA
AUDITOR GENERAL

**MELANIE M. CHESNEY**
DEPUTY AUDITOR GENERAL

September 28, 2023

Members of the Arizona Legislature

The Honorable Katie Hobbs, Governor

Mr. David Lujan, Cabinet Executive Officer/Executive Deputy Director
Arizona Department of Child Safety

Transmitted herewith is the Auditor General's report, *Arizona Department of Child Safety—Licensed Foster Care Provider Oversight*. This report is in response to a December 17, 2020, resolution of the Joint Legislative Audit Committee. The performance audit was conducted as part of the sunset review process prescribed in Arizona Revised Statutes §41-2951 et seq. I am also transmitting within this report a copy of the Report Highlights to provide a quick summary for your convenience.

As outlined in its response, the Arizona Department of Child Safety agrees with all the findings and plans to implement or implement in a different manner all the recommendations. My Office will follow up with the Department in 6 months to assess its progress in implementing the recommendations. I express my appreciation to Cabinet Executive Officer/Executive Deputy Director Lujan and Department staff for their cooperation and assistance throughout the audit.

My staff and I will be pleased to discuss or clarify items in the report.

Sincerely,

*Lindsey A. Perry*

Lindsey A. Perry, CPA, CFE
Auditor General

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# Report Highlights

Arizona Auditor General
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# Arizona Department of Child Safety
## Licensed Foster Care Provider Oversight

**Department problems related to investigating, taking enforcement action against, and monitoring licensed out-of-home care providers could result in risky or unhealthy environments for children in out-of-home care**

## Audit purpose

To determine whether the Department investigated and resolved licensing complaints against and conducted ongoing monitoring of licensed child welfare agencies and foster homes consistent with State law and best practices.

## Key findings

The Department:

- Is responsible for overseeing licensed child welfare agencies/group homes (group homes) and foster homes that care for children placed under the Department's legal custody. This responsibility includes investigating licensing complaints, taking enforcement action when necessary, and conducting ongoing monitoring of licensees.
- Was slow to investigate 15 of 28 licensing complaints we reviewed, taking 158, 171, and 406 days to investigate 3 of these licensing complaints. Slow investigations may have (1) allowed licensees to continue operating with unhealthy or risky environments that do not meet licensing standards and (2) contributed to the Department not fully investigating licensing complaints due to an inability to interview or obtain information from involved individuals.
- Did not interview most children involved in 4 of 28 licensing complaints we reviewed and did not investigate all allegations in 1 of these licensing complaints, which could have compromised investigation outcomes and the Department's determinations of potential licensing violations that could pose risks to children.
- Did not take timely enforcement action for 6 validated foster home licensing complaints we reviewed and did not effectively use its enforcement authority for 6 validated group home licensing complaints we reviewed, such as not reviewing licensees' violation history when determining enforcement actions. This may have allowed licensees to continue operating with uncorrected violations that could have contributed to risky or unhealthy environments.
- Did not perform any ongoing monitoring of 35 group homes during the 16-month period we reviewed.
- Lacked written guidance and time frames for key parts of its licensing complaint investigation and enforcement processes, including procedures for risk-based prioritization of licensing complaint investigations and determining appropriate enforcement actions.

## Key recommendations

The Department should develop and implement policies, procedures, and/or written guidance that include:

- Time frames for each key step of its licensing complaint investigation and enforcement processes, risk-based prioritization of investigations, guidance for researching foster home and group home licensee violation history, and procedures for interviewing staff and children during licensing complaint investigations.
- A graduated system of enforcement actions for validated licensing complaints that specifies the violations that would lead to different enforcement actions and mitigating and/or aggravating factors staff should consider.
- Procedures for ongoing group home monitoring.
- Processes for tracking and ensuring staff compliance with its licensing complaint investigation and enforcement processes and group home monitoring, including supervisory review and managerial oversight.

See Performance Audit Report 23-113, September 2023, at www.azauditor.gov.

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# INTRODUCTION

The Arizona Auditor General has released the second in a series of 3 audit reports of the Arizona Department of Child Safety (Department) as part of the Department's sunset review. This performance audit determined whether the Department has investigated and resolved licensing complaints against and conducted ongoing monitoring of licensed child welfare agencies and foster homes consistent with State law and best practices (see textbox for information on child welfare agencies, foster homes, and other key terms). The first performance audit determined whether the Department complied with statute by providing information necessary for local foster care review boards to complete case reviews of children in out-of-home care and whether Department specialists (caseworkers) complied with the Department's local board case review attendance policy; and included a Questions and Answers section related to the Department's provision of access to the Department's case management system, Guardian, to the Arizona Ombudsman-Citizens' Aide.[1] The third and final audit report will provide responses to the statutory sunset factors.

## Key terms

**Child welfare agency—**An organization licensed by the Department to receive and care for children in a group home or shelter.[1] A child welfare agency can operate more than 1 group home or shelter under its license.

**Dependent—**Determination by a juvenile court that a child is in need of proper and effective parental care and control. The court must decide on the dependent child's services and placement, including out-of-home care.

**Foster home—**Residence maintained by a foster parent licensed by the Department to care for children placed in foster care.[2]

**Group home—**A residential facility operated by a licensed child welfare agency to provide children 24-hour supervision in a group care setting. Group homes must have Department-issued operating certificates when located separate from a child welfare agency's administrative office.

**Licensing agency—**An organization contracted by the Department to assist prospective foster parents in applying for a foster home license, and to monitor the activities of foster homes.

**Out-of-home care—**The placement and services involving a dependent child who has been removed from their home and placed with a relative, licensed foster home, or in congregate care such as a group home.

[1] Child welfare agencies do not include State-operated institutions or facilities, juvenile detention facilities, or healthcare institutions licensed by the Arizona Department of Health Services.

[2] When the Department places dependent children with a relative or other individual with whom they have a significant relationship, the relative or other individual is not required to obtain a foster home license.

Source: Auditor General staff review of State statute and Department rules and policy.

[1] See Arizona Auditor General report 23-102 *Arizona Department of Child Safety—Information provided to local foster care review boards and State Ombudsman*.

## Department is statutorily responsible for protecting children

The Department is statutorily responsible for protecting children in Arizona, including by investigating allegations of abuse and neglect.[2] Specifically, as required by statute, the Department operates and maintains a centralized hotline for the public to report alleged child abuse and neglect, and is responsible for investigating these allegations.[3,4] Additionally, Department policy outlines criteria for its investigators to determine whether any child in a home where abuse or neglect was alleged to have occurred is in present or impending danger. Investigators are required to implement a plan to ensure a child's safety when the child is found to be in present or impending danger, which may include removing the child from the home and placing the child in the temporary custody of the Department.[5,6]

Additionally, the Department is responsible for overseeing the placement and managing the cases of children who have been adjudicated dependent by the juvenile court and placed under the Department's legal custody while in out-of-home care, including placements with Department-licensed child welfare agencies and foster homes, and employs caseworkers to help it meet this responsibility.[7,8,9] As part of this responsibility, Department policy requires caseworkers to make contact with each assigned caseload child and caregiver at least once a month with the majority of contact occurring at the child's placement. Caseworkers are responsible for assessing various factors during these contacts, including but not limited to the safety of the child, the ability of the caregiver to meet the child's needs, the safety of the physical home environment such as any observable hazardous conditions, and the developmental progress of the child.

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[2] Arizona Revised Statutes (A.R.S.) §8-451(B).

[3] A.R.S. §§8-451, 8-455, and 8-456.

[4] Pursuant to A.R.S. §8-201(2), abuse is defined as the infliction or allowing of physical injury, impairment of bodily function or disfigurement, or the infliction of or allowing another person to cause serious emotional damage as evidenced by severe anxiety, depression, withdrawal, or untoward aggressive behavior and which is diagnosed by a medical doctor or psychologist and is caused by the acts or omissions of an individual who has the care, custody, and control of a child. Abuse includes inflicting or allowing sexual abuse, sexual assault, child sex trafficking, or other sexual exploitation of a child; physical injury resulting from allowing a child to enter or remain in a structure or vehicle with toxic chemicals or equipment for the purpose of manufacturing dangerous drugs; and unreasonable confinement of a child. Pursuant to A.R.S. §8-201(25), neglect includes the inability or unwillingness of a parent, guardian, or custodian of a child to provide that child with supervision, food, clothing, shelter, or medical care if that inability or unwillingness causes substantial risk of harm to the child's health or welfare, except if the inability to provide services to meet the needs of a child with a disability or chronic illness is solely the result of the unavailability of reasonable services; and a determination by a health professional that a newborn infant was exposed prenatally to certain drugs or substances and the exposure was not the result of a medical treatment administered to the mother or newborn.

[5] According to Department policy, safety planning consists of taking actions or providing resources to ensure a child's basic needs and safety are met, including obtaining resources for the family, such as food or housing; providing crisis intervention and counseling; and identifying a responsible adult who is available to be present in the home to address dangers to the child.

[6] A.R.S. §8-821 authorizes the Department to take a child into temporary custody pursuant to an order of the superior court, with the consent of the child's parent or guardian, or if temporary custody is clearly necessary to protect the child from serious harm in the time it would take to obtain a court order and either of the following is true: (1) there is no less-intrusive alternative that would reasonably and sufficiently protect the child's health or safety or (2) probable cause exists to believe the child is a victim of sexual or serious physical abuse. Additionally, children must not remain in temporary custody for more than 72 hours (excluding weekends and holidays) unless a dependency petition is filed.

[7] Pursuant to A.R.S. §8-201(15), dependent children include those whose parents or guardians are unwilling or incapable of exercising parental care and control, and children whose home is unfit because of abuse, neglect, cruelty, or depravity by a parent or any other person having custody or care of the child.

[8] As of May 2023, the Department reported 11,072 children and young adults in out-of-home care, and 892 of these were 18 years or older and were primarily placed in either a group home or an independent living arrangement. See Department's June 2023 *Monthly Operational and Outcome Report*.

[9] The juvenile court may place a dependent child in the care of the child's parents subject to Department supervision or place the child in an out-of-home placement in accordance with the child's best interests and in the order of preference outlined in statute, including but not limited to placement with grandparents or other extended family, in a licensed foster or group home, or in an independent living program for older children. See A.R.S. §8-845(A).

## Department is responsible for licensing and oversight of child welfare agencies/group homes and foster homes

**Department is responsible for licensing child welfare agencies and foster homes—**The Department has established the Office of Licensing and Regulation (OLR) to carry out its responsibility to issue licenses to child welfare agencies and foster homes that have met qualifications for licensure in Arizona.[10] Once licensed, child welfare agencies; facilities that operate under these agencies, including group homes; and foster homes must meet various standards outlined in Department rules, such as maintaining facilities and homes that are clean, sanitary, and in good repair; safeguarding potentially dangerous objects such as firearms and highly toxic substances, including gasoline and pesticides; properly storing medications; and ensuring pools are properly fenced. As of July 2023, the Department reported there were 85 child welfare agencies and 2,514 foster homes actively licensed in the State. Additionally, the Department reported there were 254 group homes and 13 shelters operated by these 85 child welfare agencies.[11,12]

**Department is responsible for investigating complaints alleging licensing violations by child welfare agencies and foster homes—**The Department's rules require it to investigate complaints related to potential violations of licensing standards (licensing complaints) by child welfare agencies; facilities that operate under these agencies, including group homes; and foster homes.[13] The Department has assigned this responsibility to OLR. According to Department policy, the Department should assign OLR licensing complaints for investigation by using its child welfare information technology system, Guardian. As seen in Figure 1, pages 5 and 6, the Department's processes for investigating complaints against foster homes and child welfare agencies/group homes are as follows:

- Foster home licensing complaints are assigned to OLR's foster home division, which then assigns the complaint to a contracted licensing agency to conduct the investigation (see textbox, page 1, for a definition of contracted licensing agency).[14]
- Child welfare agency/group home licensing complaints are assigned to OLR's child welfare agency division for investigation by an OLR licensing specialist.

For both foster home and child welfare agency/group home licensing complaints, if an investigation validates that a licensing violation occurred, OLR is responsible for and authorized to take enforcement actions against the licensee, up to and including suspension or revocation of the license. For example, if a contracted licensing agency's investigation validates a licensing complaint against a foster home, and OLR finds there is reasonable cause to believe the violation poses a risk to the health, safety, or welfare of a child, OLR is required to take action such as suspending or revoking the foster home license.[15] Additionally, if an OLR investigation validates a licensing complaint against a child welfare agency/group home that does not jeopardize a child's health or safety, the Department may place the agency on a corrective action plan to address the deficiency.[16] See Figure 1, pages 5 and 6, for additional information about the Department's processes for screening, investigating, and resolving licensing complaints, and see Finding 1, pages 7 through 22, for more information on our findings related to the Department's licensing complaint-handling processes.

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[10] A.R.S. §§8-505 and 8-509.

[11] Licensed child welfare agencies must apply for an operating certificate for each group home or shelter facility the agency plans to operate separate from its administrative offices. As of July 31, 2023, the Department reported its 85 licensed child welfare agencies operated the following facilities: 48 group homes or shelters located at the child welfare agency's administrative offices and 219 standalone group homes or shelters. See AAC R6-5-7409 and 7410.

[12] The Department contracts with licensed child welfare agencies with which it places children under the Department's custody.

[13] Arizona Administrative Code (AAC) R21-6-418 contains rules governing foster home licensing complaints and AAC R6-5-7417 contains rules governing child welfare agency/group home licensing complaints.

[14] According to the Department, it intends to hire staff to conduct foster home licensing complaint investigations and remove this responsibility from its contracted licensing agencies beginning in February 2024.

[15] AAC R21-6-418.

[16] AAC R6-5-7418.

**Department has different processes for investigating reports of abuse and/or neglect against child welfare agencies and foster homes—**In contrast to the Department's licensing complaint investigation processes previously discussed, the Department has other processes for investigating allegations of abuse or neglect against licensed foster homes or child welfare agencies/group homes. Specifically, according to Department policy, investigations regarding child abuse or neglect allegations against licensed foster homes and only child abuse allegations against licensed child welfare agencies are the responsibility of OLR investigative specialists or Department Office of Child Welfare Investigations (OCWI) investigators if the allegation involves criminal conduct.[17] These investigators are statutorily required to be trained to investigate allegations of child abuse/neglect. However, once an investigation of an abuse or neglect allegation by these investigators is completed, OLR licensing specialists are responsible for reviewing the investigation findings to determine if the child welfare agency or foster home violated any licensing standards and if OLR should take enforcement action, up to and including suspension or revocation of the agency or home's license.

After we completed our audit work, the Department reported that as of June 30, 2023, it stopped investigating allegations of abuse against child welfare agency staff because it determined that they do not meet the statutory definition of caregiver and therefore those allegations need to be investigated by law enforcement. The Department reported that instead, Department staff will notify law enforcement about these allegations, open a licensing complaint investigation related to the child welfare agency that employs the individual, and investigate whether any licensing violations occurred.

**Department is responsible for ongoing monitoring of licensees—**As required by rule, the Department's contracted licensing agencies are responsible for conducting ongoing monitoring of the Department's licensed foster homes.[18] Specifically, at least once every 3 months, licensing agencies are required to conduct assessments, monitoring, and on-site visits of foster homes, at least 1 of which must be an unannounced site visit, to ensure that foster homes meet licensing standards (see Arizona Auditor General report 23-115 for more information on our review of the Department's process for overseeing licensing agencies' foster home monitoring).[19] Additionally, the Department's rules require it to monitor the ongoing operations of child welfare agencies, including group homes, to ensure they meet licensing standards (see Finding 1, pages 15 and 16, for more information on our review of the Department's group home monitoring).[20] For example, the Department's rules authorize various monitoring activities for child welfare agencies/group homes, including announced and unannounced inspections to check that facilities have proper sleeping arrangements, are clean and sanitary, and have safeguarded potentially dangerous objects such as chemicals and firearms; interviews with children and staff to assess child wellbeing and whether staff are following agency policies and procedures; and observations of program activities to verify whether children are provided access to appropriate recreational, cultural, and community activities.

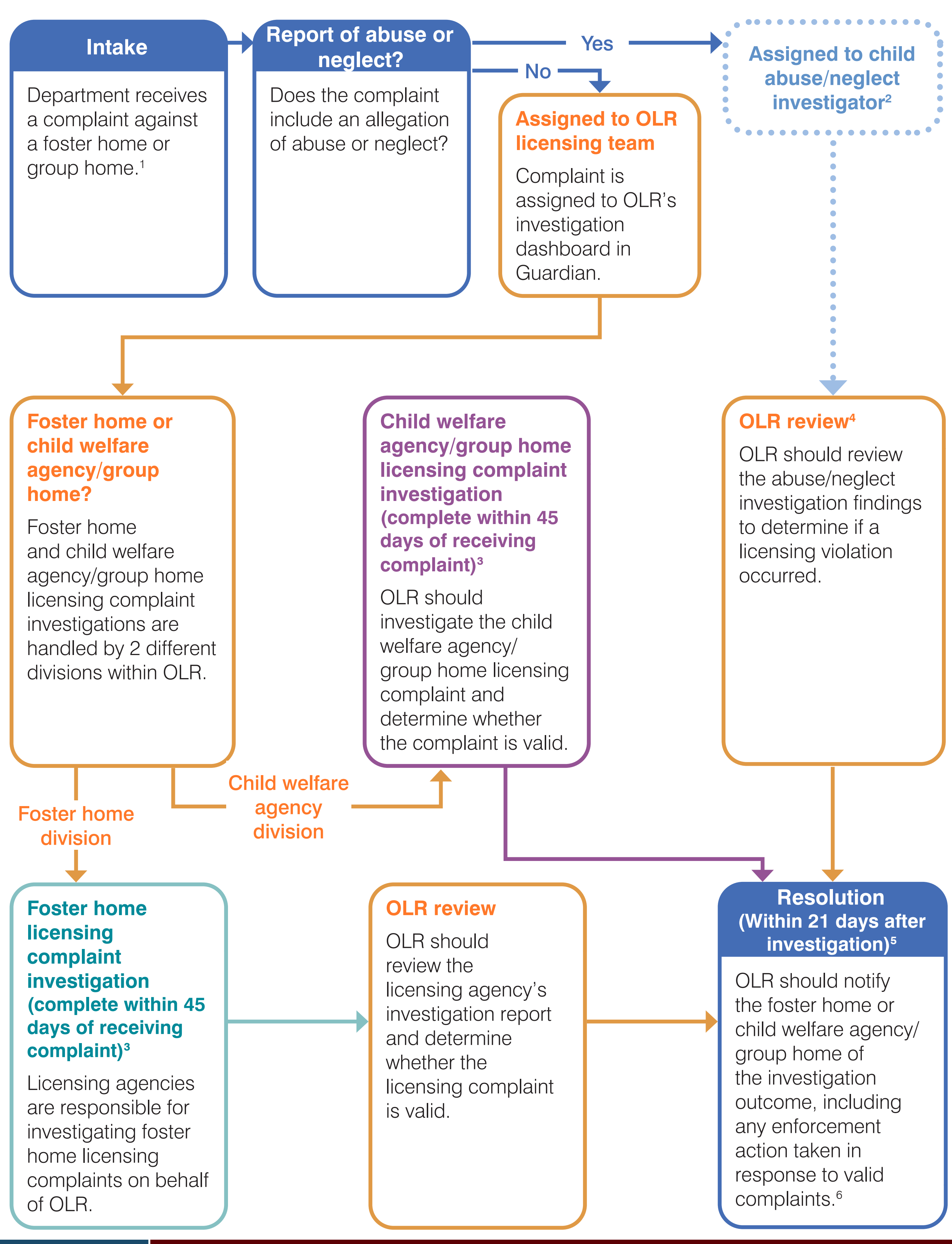
[17] During the audit, Department policy required Department staff to investigate abuse allegations against licensed child welfare agencies/group homes but did not require it to investigate allegations of neglect against child welfare agencies/group homes. The Department reported that in 2019, under a previous administration, it revised its policy to remove the requirement to investigate neglect allegations because it determined that child welfare agency/group home staff do not meet the statutory definition of caregiver. As of June 30, 2023, and under the new administration, the Department reported it stopped investigating allegations of abuse against child welfare agency staff after making a similar determination. As a result, the Department no longer investigates allegations of abuse or neglect against child welfare agencies.

[18] AAC R21-6-218.

[19] See Arizona Auditor General report 23-115 *Arizona Department of Child Safety—Sunset review*.

[20] AAC R6-5-7416.

**Figure 1**
Department's OLR responsible for investigating and resolving licensing complaints



## Figure 1 continued

[1] The Department can receive complaints related to licensed child welfare agencies/group homes and foster homes in several ways, including through its centralized hotline, self-reports by licensees, and according to the Department, from other Department staff such as caseworkers or contracting staff, and directly to OLR from members of the public.

[2] According to Department policy, investigations regarding child abuse or neglect allegations against licensed foster homes and child abuse allegations against child welfare agencies are the responsibility of OLR investigative specialists trained to investigate the allegations or Department Office of Child Welfare Investigations investigators if the allegation involves criminal conduct. However, according to the Department, as of June 30, 2023, it stopped investigating allegations of abuse against child welfare agency staff because it determined that they do not meet the statutory definition of caregiver and therefore those allegations need to be investigated by law enforcement. The Department reported that instead, Department staff will notify law enforcement about these allegations, open a licensing complaint investigation related to the child welfare agency that employs the individual, and investigate whether any licensing violations occurred.

[3] AAC R21-6-221 requires licensing agencies to complete foster home licensing complaint investigations within 45 days. Further, although not yet implemented at the time of our review, the Department had draft procedures that required all licensing complaint investigations to be similarly completed within 45 days. Therefore, we assessed the Department's investigation timeliness for all licensing complaints we reviewed based on a 45-day time frame from the time the Department receives a complaint to when it completes its investigation (see Finding 1, pages 9 and 10, for more information on our findings related to the Department's complaint investigation timeliness).

[4] Once an investigation of an abuse or neglect allegation involving a licensed agency/home is completed, OLR is responsible for reviewing the investigation findings to determine if the child welfare agency or foster home violated any licensing standards and if OLR should take enforcement action, up to and including suspension or revocation of the agency or home's license.

[5] Department policy also requires OLR to take enforcement action, as necessary, within 21 days after the end of a foster home investigation, and the Department has drafted but not yet implemented a similar policy that requires OLR to resolve a complaint that a child abuse/neglect investigator has investigated and take enforcement action, as necessary, against the licensee within 21 days after receiving an abuse or neglect investigation report. We have assessed the Department's timeliness in resolving and taking enforcement action for all licensing complaints we reviewed based on this 21-day time frame (see Finding 1, pages 11 through 13, for more information on our findings related to the Department's timeliness in taking enforcement action in response to validated foster home and group home licensing complaints).

[6] The Department's rules authorize various enforcement actions in response to valid foster home and child welfare agency/group home licensing complaints, such as requiring corrective action plans or suspending or revoking a license (see Finding 1, page 13, for additional information about these authorized enforcement actions).

Source: Auditor General staff review of Department rules and policy and documents provided by Department staff.

# Department problems related to investigating, taking enforcement action against, and monitoring licensed providers for children in out-of-home care could result in children being in risky or unhealthy environments

In May 2022, a child welfare agency contacted the Department to self-report that employees from 1 of its group homes were involved in an altercation that children witnessed. Specifically, according to the child welfare agency's report and the Department's investigation record, 2 group home employees were accompanying multiple children to a drug testing facility when another employee of the group home arrived at the facility, assaulted and left 1 of the other employees unconscious, and then fled the scene with the remaining group home employee. The children observed the incident but were not involved in the assault, and police contacted the child welfare agency after being called to the scene. All employees who were involved in the incident resigned or were fired by the child welfare agency.

Although Department caseworkers met with at least some of the children affected by the incident to assess their safety, the self-reported licensing complaint was not assigned to investigators' Guardian dashboard for 111 days.[21] Forty-seven days after the licensing complaint appeared on investigators' dashboard, OLR licensing specialists initiated an investigation of the licensing complaint. On that same day, they completed the investigation, validating the licensing complaint. Two days later—a total of 160 days after receiving the licensing complaint—the Department decided to take no further corrective action against the child welfare agency. According to the Department's investigation record, it decided to take no further corrective action against the child welfare agency because the employees involved in the incident had either resigned or were fired, and the child welfare agency reported that it had made behavioral health services available to the children who witnessed the incident. However, the Department did not document verifying whether the children who witnessed the incident received services and did not interview the children during its investigation to determine if a licensing violation had occurred.

According to the Department's investigation record, the child welfare agency employee who was the perpetrator in the incident had previously been reprimanded for not conducting periodic child bed checks as required by group home policy. Further, residents of another group home operated by the same child welfare agency had previously reported to group home staff that they had observed an inappropriate romantic relationship between employees who had been involved in the May 2022 incident. However, Department licensing staff had not conducted any monitoring activities at that group home since at least January 2022, such as interviews with group home

[21] This was related to a Department-reported software issue in Guardian (see page 18 for additional information about this issue).

residents, and were likely not aware of these employees' relationship until interviewing the CEO of this child welfare agency for this investigation.[22] Finally, this child welfare agency was the subject of at least 5 other prior, validated licensing complaints related to childcare issues or a lack of supervision of group home residents, including leaving a child with sexual maladaptive behaviors unsupervised in public and staff not conducting periodic bed checks, which the prior investigation concluded contributed to a child's drug overdose death. However, for each of these 2 validated licensing complaints, the Department decided to take no further corrective action because the child welfare agency provided training to its staff and/or fired the employees involved in the violations.

This group home licensing complaint is one of many licensing complaints our review identified that illustrates various problems with the Department's oversight of licensed foster homes and/or group homes that could allow licensees to operate with uncorrected violations that contribute to risky or unhealthy environments.

## Department was slow and ineffective in investigating and taking enforcement action for some foster home and group home licensing complaints we reviewed and did not perform ongoing monitoring of group homes we reviewed, which could result in risky or unhealthy environments for children in out-of-home care

As illustrated in Figure 1 in the Introduction (see pages 5 and 6), the Department's complaint investigation and enforcement processes for foster homes and group homes include several steps, both ending with the Department notifying the licensee of the investigation outcome and the enforcement action(s) taken by the Department, if any. Also, as discussed in the Introduction (see page 4), the Department is responsible for ongoing monitoring of child welfare agencies, including group homes, to ensure that the facilities meet licensing standards. Our review of 30 of 1,389 foster home and group home licensing complaints the Department received and documented in Guardian in calendar year 2022 and had resolved as of March 20, 2023, found investigation and enforcement problems with some of these complaints.[23,24] Further, our review of 35 of the 296 child welfare agency administrative offices and associated group homes operated by child welfare agencies actively licensed as of March 29, 2023, found that the Department did not conduct ongoing monitoring activities as required by rule for any of the 35 facilities during the period of January 1, 2022 through April 30, 2023.[25,26] These issues, each of which could result in risky or unhealthy environments for children in out-of-home care, are detailed in the following 3 issue sections.

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[22] Although the Department reported that caseworkers would have met with children on a monthly basis to ensure their safety, the licensing complaint investigation record did not include any information indicating whether children had told caseworkers about the group home staff's inappropriate romantic relationship.

[23] We selected a stratified random sample of 15 of 666 foster home and group home complaints for which the Department documented taking no further action in response to the complaint; and 15 of 723 complaints for which the Department documented taking some action, such as requiring a corrective action plan. Our sample included 28 licensing complaints OLR or a licensing agency investigated and 2 allegations of abuse or neglect for which OLR reviewed the investigation findings; as such, we removed the 2 allegations of abuse or neglect from our analysis of the timeliness of OLR's licensing complaint investigations (see Appendix A, page a-1, for additional information about our sample).

[24] We found several data reliability issues with the Department's licensing complaint investigations portal in Guardian, including that Guardian does not include data fields to record an investigation start date, the investigation completion date, or the date of any enforcement action taken in response to a licensing complaint; and that some data fields are not consistently filled in, such as whether a licensing complaint was validated. Additionally, the population of licensing complaints we reviewed may be inaccurate because of duplicate licensing complaint entries we identified. See pages 17 and 18 for additional information about the licensing complaints data reliability issues we identified.

[25] The Department reported it did not conduct monitoring for 1 of these 35 group homes because the group home never received any children.

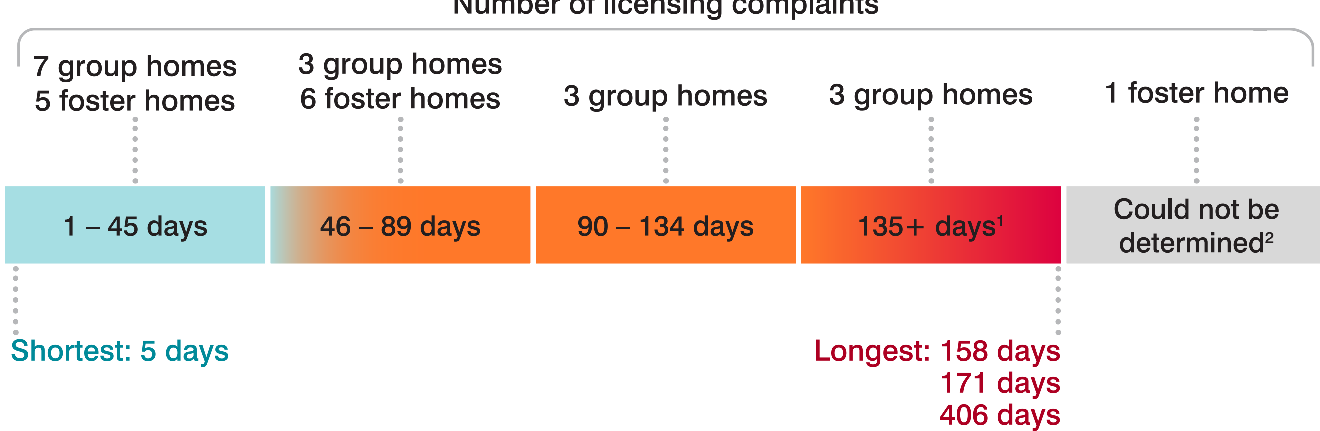
[26] We selected a sample of administrative offices and facilities operated by the 85 child welfare agencies licensed as of March 29, 2023. Specifically, we selected a random sample of 30 of 296 child welfare agency administrative offices and associated group home or shelter facilities and judgmentally selected an additional 5 of the remaining 266 facilities to review as follows: 1 facility that is not contracted with the Department, 1 facility for children with significant trauma, and 3 facilities with a history of licensing complaints (see Appendix A, page a-1, for additional information about our sample).

# Issue 1: Department was slow to investigate 15 of 28 licensing complaints we reviewed and did not interview all children involved in 4 licensing complaints

**The Department was slow to complete investigations of 6 foster home and 9 group home licensing complaints we reviewed, which resulted in Department delays in identifying and addressing licensing violations and it not fully investigating all licensing complaints related to risky or unhealthy environments—**As discussed in the Introduction (see Figure 1, pages 5 and 6, footnote 3), to determine if licensing complaints are valid, administrative rule requires licensing agencies to complete foster home licensing complaint investigations within 45 days. Further, the Department's draft procedures developed at the time of our audit also required OLR to complete group home licensing complaint investigations within 45 days (see pages 11 through 13 for more information on the Department's time frames for OLR to take enforcement action, as necessary, in response to validated licensing complaints).[27] However, as shown in Figure 2, our review of the 28 licensing complaints included in our sample of 30 of 1,389 foster home and group home complaints found that the Department did not complete its investigations of 15 of them within 45 days—the Department took between 48 and 71 days to investigate 6 foster home licensing complaints we reviewed, and between 49 and 406 days to investigate 9 group home complaints we reviewed. In fact, the Department took as long as 158, 171, and 406 days, respectively, to investigate 3 of these group home licensing complaints.[28]

**Figure 2**

**Department took between 5 and 406 days to complete investigations for the 12 foster home and 16 group home licensing complaints we reviewed**




[1] The Department reported these 3 complaints were affected by a Guardian software issue, which delayed investigators from being able to view within Guardian that the complaints had been assigned to them for between tens and hundreds of days (see page 18 for additional information about this issue).

[2] We could not determine the investigation end date for 1 complaint because this was not documented in Guardian (see page 17 for additional information about this issue).

Source: Auditor General staff review of investigation reports and other documents provided by the Department and information in Guardian for the 28 sampled licensing complaints.

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[27] AAC R21-6-221 requires licensing agencies to complete foster home licensing complaint investigations within 45 days. Further, although not yet implemented at the time of our review, the Department had draft procedures that required all licensing complaint investigations to be completed within 45 days. Therefore, we assessed the Department's investigation timeliness for all licensing complaints we reviewed based on a 45-day time frame from the time the Department receives a complaint to when it completes its investigation.

[28] We excluded 2 of 30 sampled complaints from our OLR investigation timeliness review because these 2 complaints included allegations of abuse or neglect, and thus OLR was not responsible for investigating them (see Introduction, pages 2 through 6, for more information on the Department's responsibilities for investigating allegations of abuse and neglect).

Slow investigations may have allowed licensees to continue operating with unhealthy or risky environments that do not meet licensing standards and also contributed to the Department's not fully investigating licensing complaints by being unable to interview or obtain information from involved individuals. Specifically, slow complaint investigations may have resulted in:

- **The Department not identifying and addressing licensing violations for extended periods of time—**For example, 1 group home licensing complaint we reviewed alleged a resident was under the influence of substances, in possession of a vape pen, and endangering their baby who was placed in the group home with them. Although a Department caseworker conducted a safety assessment of the baby 3 days after the Department received the complaint, OLR staff took 122 days to complete its licensing investigation and validate that group home staff committed a licensing violation by not intervening to ensure the safety of the group home resident's baby. During the time it took OLR staff to investigate this licensing complaint, the group home continued to operate under an active child welfare agency license and thus continued to provide care to children although it may not have met licensing standards related to child supervision. The group home also had 3 prior licensing complaints, 1 of which the Department determined there was a licensing violation related to lack of supervision and care for group home residents, and validated that the group home had not conducted a thorough room search where the resident had unsanitary conditions in the room, including soiled diapers and maggots.

- **The Department not fully investigating licensing complaints, including by not being able to interview or obtain information from involved individuals—**For 3 group home licensing complaints we reviewed, the children and/or staff involved in the complaint had left the group home before the Department conducted its investigation, and therefore the investigator reported that the children and/or staff could not be interviewed. For example, the Department took 406 days to conduct its investigation of a group home complaint involving a child hiding sharp objects in their room and threatening staff and other children at the home. By the time the Department staff conducted their investigation, only 1 employee from the time of the allegation remained employed at the group home, but this employee could not recall the alleged incident. The Department's investigation record reported its staff closed the complaint with a disposition of "no action taken" because it could not gather enough evidence to investigate the complaint and reach a conclusion about whether a licensing violation occurred.

**The Department did not interview most children involved in 4 of 28 licensing complaints we reviewed and did not investigate all allegations in 1 of these licensing complaints, which could have compromised investigation outcomes and the Department's determinations concerning potential licensing violations that could pose risks to children—**Rule authorizes the Department to interview all staff and/or children residing in a foster home or group home during its investigations.[29] Further, the Child Welfare League of America (CWLA) recommends that interviews should be conducted with children involved with or affected by an allegation, as well as all other children living in the foster or group home in order to determine if other licensing violations or potential abuse/neglect occurred beyond what was alleged in the complaint.[30] However, as seen in Table 1 (see page 11), for at least 4 of the 28 licensing complaints we reviewed, the Department's investigation record indicated that it did not interview most of the children involved in the alleged violation. In fact, for these 4 licensing complaints, the Department had only interviewed 1 of the 11 children involved in the alleged violation despite it having the ability to interview all 11 children. The Department's not interviewing all individuals involved with a licensing complaint results in an incomplete investigation and may prevent it from having a full understanding of and coming to an accurate conclusion regarding the licensing complaint and could also compromise the Department's determinations concerning potential licensing violations that could pose risks for children in the home. For example, 1 group home licensing complaint we reviewed alleged that an employee had hugged a child and touched the child's face against the child's will. Although the child's caseworker met with the child after the complaint was received, the Department's licensing complaint investigation record did not include any information from the

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[29] AAC R6-5-7417 and R21-6-221.

[30] Child Welfare League of America (CWLA). (2003). *CWLA best practice guidelines: Child maltreatment in foster care*. Washington, DC. Retrieved 7/6/2023 from https://www.hunter.cuny.edu/socwork/nrcfcpp/downloads/policy-issues/maltreatment-guidelines.pdf.

caseworker's conversations with the child and OLR licensing specialists did not interview the child or any other children from the home. The only interviews the Department documented in the investigation record were conducted over the phone and were with the accused employee and other staff. The Department did not validate any licensing violations related to the complaint.

**Table 1**

**Department did not interview most children involved in 1 foster home and 3 group home licensing complaints of 28 licensing complaints we reviewed[1]**

| Complaint | Children involved[1] | Licensee |
|---|---|---|
| 1 | 2 not interviewed | Foster home |
| 2 | 5 not interviewed | Group home |
| 3 | 1 not interviewed | Group home |
| 4 | 1 interviewed, 2 not interviewed | Group home |

Not interviewed

Interviewed

[1] Children involved include those affected by and/or witnesses of the violation/incident as documented in the Department's investigation record.

Source: Auditor General staff review of investigation reports and other documents provided by the Department and information in Guardian for the 28 sampled licensing complaints.

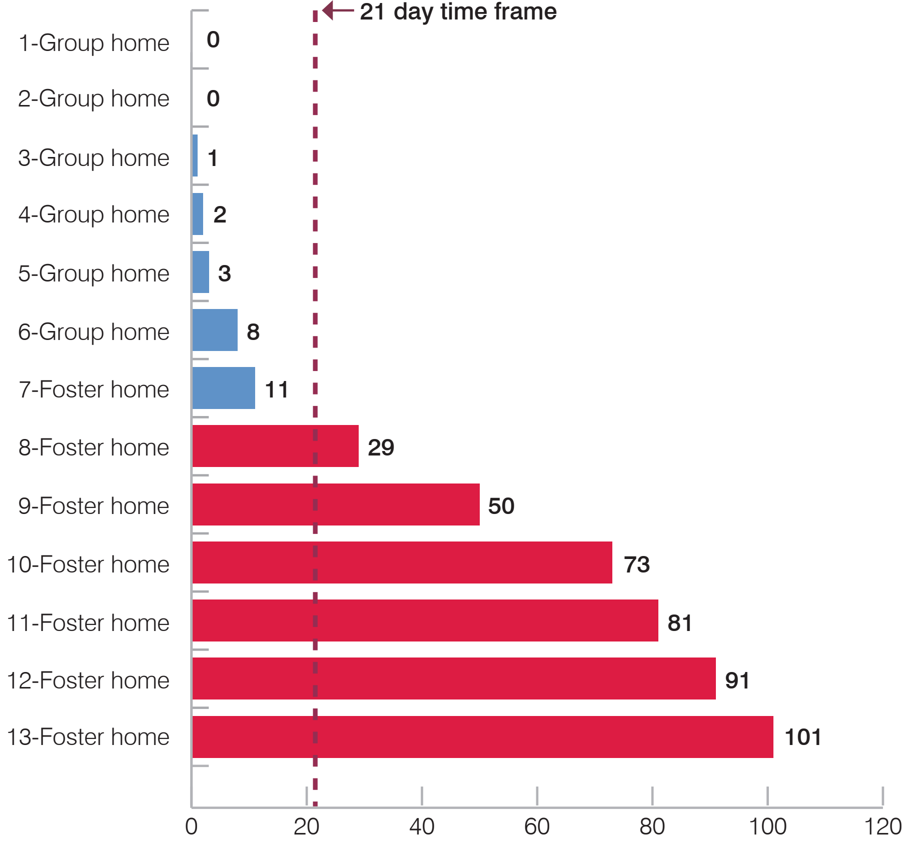
Additionally, the Department combined this same complaint with another licensing complaint involving the same child after the child expressed feeling unsafe at the group home and was found to have bruises on their body. However, the Department did not document investigating the bruising issue. Further, the bruising was not mentioned in the Department's letter it sent to the licensee explaining that the Department did not validate the other complaint related to an employee hugging a child and touching their face against the child's will.

## Issue 2: Department was slow to take enforcement action for 6 foster home licensing complaints we reviewed and did not effectively use its enforcement authority for 6 group home licensing complaints we reviewed

**The Department did not take timely enforcement action for 6 validated foster home licensing complaints we reviewed, which may have allowed licensees to continue operating with uncorrected violations that could have contributed to risky or unhealthy environments—** National State Auditors Association (NSAA) best practices indicate that regulatory agencies should take timely

enforcement actions to address violations identified during their licensing complaint-handling investigations.[31] The Department had a 21-day time frame in place for taking enforcement action in response to validated licensing complaints against foster homes during the time of our review, and we used this standard for all the licensing complaint investigations we reviewed.[32] Specifically, as shown in Figure 3, for 6 of 13 validated licensing complaints from our sample of 30 complaints, all 6 of which were for foster homes, the Department took more than 21 days to take enforcement action once licensing agencies had completed the investigations.[33] In fact, for 4 of these validated licensing complaints, the Department took from nearly 2.5 months to nearly 3.5 months to take enforcement action.

**Figure 3**
**Department took 0 to 11 days to take enforcement action after investigations were concluded for 6 validated group home and 1 foster home licensing complaints we reviewed, but took 29 to 101 days to take enforcement action for 6 validated foster home licensing complaints**




Source: Auditor General staff review of investigation reports and other documents provided by the Department and information in Guardian for the 30 sampled licensing complaints.

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[31] Auditor General staff review of National State Auditors Association (NSAA). (2004). *Carrying out a state regulatory program: A National State Auditors Association best practices document*. Lexington, KY. Retrieved 3/15/2023 from https://www.nasact.org/files/News_and_Publications/White_Papers_Reports/NSAA%20Best%20Practices%20Documents/2004_Carrying_Out_a_State_Regulatory_Program.pdf.

[32] Department policy requires OLR to take enforcement action, as necessary, within 21 days after the end of a foster home investigation, and the Department has drafted but not yet implemented a similar policy that requires OLR to take enforcement action, as necessary, against the licensee within 21 days after receiving an abuse or neglect investigation report. We have assessed the Department's timeliness in resolving and taking enforcement action for all licensing complaints we reviewed based on this 21-day time frame.

[33] As discussed in footnote 28 on page 9, our sample of 30 complaints included 28 licensing complaints OLR or a licensing agency investigated and 2 allegations of abuse or neglect for which OLR reviewed the investigation findings.

When the Department is slow to take enforcement action, licensees may continue operating with uncorrected violations that contribute to risky or unhealthy environments. For example, for 1 foster home licensing complaint, the Department took 91 days to take enforcement action after it validated that the licensee left a child unsupervised despite the child's history of self-harm. The Department took enforcement action against the licensee by requiring them to sign a new statement of understanding, review licensing standards related to supervisory responsibilities, and complete training on child safety and supervision.

**The Department did not effectively use its enforcement authority for some group home licensing complaints we reviewed, which may have allowed licensees' systemic problems or noncompliance to remain uncorrected, which could contribute to risky or unhealthy environments—**Our review of the 13 validated licensing complaints also found problems with how the Department used its enforcement authority. Specifically:

- **Department did not take sufficient enforcement action for 3 validated group home licensing complaints we reviewed—**The Department's rules require it to take enforcement action in response to licensing complaints it validates and authorizes several different enforcement actions. Specifically, the Department must at least require a corrective action plan when it validates a licensing complaint against a child welfare agency, including a group home, whereas for a foster home, the Department can take no action if the violation was sufficiently corrected at the time of the investigation, or require a corrective action plan. Further, for both foster homes and child welfare agencies/group homes, the Department can suspend or revoke a license (see textbox for more information about the Department's authorized enforcement actions).

  However, for 3 group home licensing complaints of the 13 validated licensing complaints we reviewed, the Department did not take sufficient enforcement actions despite being required by its rules to at least require the licensee to develop a corrective action plan. For example, as mentioned below on page 14, despite validating the licensing complaint, the Department did not take required enforcement action against a group home whose employee allegedly had provided children marijuana. Further, child welfare agencies operating these 3 group homes with validated licensing complaints had a history of similar prior, validated licensing complaints (see next bullet for additional information about taking progressive enforcement action in response to validated licensing complaints).

### Department's authorized enforcement actions for validated complaints

**Child welfare agencies/group homes**

- Child welfare agency corrective action plan
- Convert child welfare agency license to provisional status[1]
- Suspend or revoke child welfare agency license or a specific facility's operating certificate

**Foster homes**

- No further action if the violation was sufficiently corrected at time of investigation
- Corrective action plan
- Suspend license
- Revoke license

[1] A provisional license may be issued to a child welfare agency whose services are needed but that is temporarily unable to conform to established standards of care. A provisional license lasts no more than 6 months and may be issued only when an agency's noncompliance with standards is correctable and does not jeopardize the health, safety, or well-being of children in care.

Source: Auditor General staff analysis of AAC R21-6-414 and 416, and R6-5-7417 through 7420.

- **Department did not consider licensees' history of violations and take progressive enforcement action for 6 of 13 validated licensing complaints, which were all against group homes—**According to the Department's rules for both foster homes and group homes, if a violation associated with a validated licensing complaint can be corrected within a specified time period and does not threaten children's health or safety, the Department can consider a corrective action plan for the licensee. Its foster home and group home rules further specify that the Department must consider, among other criteria, the nature of the violation, similar prior validated licensing complaints, and the licensee's responsiveness to any prior corrective action plans.[34] Additionally, as shown in the textbox, NSAA best practices indicate that agencies should consider the licensee's history of prior violations and take progressively stringent enforcement actions against the licensee. However, for the 13 validated licensing complaints we reviewed, we found that although the Department considered licensees' history for 7 validated foster home licensing complaints, it did not do so for 6 validated group home licensing complaints (see Table 2, page 15).

**NSAA best practices for agencies to address licensing violations and enforce compliance with licensing requirements:**

- Develop systematic, fair, and progressively stringent enforcement processes to ensure that public health and welfare are protected.
- Establish a graduated and equitable system of sanctions that are set sufficiently high to help achieve the desired results.
- Specify and consider the number or severity of violations that should trigger each level of sanction.
- Take appropriate, consistent, and timely enforcement actions that address the violations cited against the regulated people/entities.

Source: NSAA, 2004.

The Department's not considering licensees' history of violations and taking progressive enforcement action for group homes could allow licensees' systemic problems or areas of noncompliance with licensing standards to remain uncorrected. For example, 1 validated licensing complaint alleged a group home employee provided marijuana to children who were residents of the group home. The Department's records indicated that when considering enforcement action, the Department ultimately decided the group home had taken sufficient corrective action by firing the employee and took no further enforcement action. However, our review of 44 prior validated licensing complaints for the child welfare agency that operates this group home since March 2021 found other specific instances of inappropriate and harmful staff interactions with children, including staff issues such as verbal abuse of children and inappropriate use of restraints causing injuries to children. For these validated complaints involving inappropriate and harmful staff interactions with children, the Department responded by requiring the child welfare agency/group home to develop a corrective action plan, but the Department did not document considering any of these prior validated licensing complaints when deciding on potential enforcement actions for the validated complaint we reviewed.

[34] See AAC R21-6-416 for provisions related to foster homes, and AAC R6-5-7418 for provisions related to child welfare agencies/group homes.

**Table 2**
**Department considered licensees' prior validated licensing complaints when deciding on enforcement action in response to 7 validated foster home licensing complaints we reviewed, but did not do so for 6 validated group home licensing complaints**

| Complaint | Licensee | Considered past valid complaints?[1] | Number of past valid complaints[2] |
|---|---|---|---|
| 1 | Foster home | Yes | 4 |
| 2 | Foster home | Yes | 2 |
| 3 | Foster home | Yes | 0 |
| 4 | Foster home | Yes | 0 |
| 5 | Foster home | Yes | 0 |
| 6 | Foster home | Yes | 2 |
| 7 | Foster home | Yes | 0 |
| 8 | Group home | No | 12 |
| 9 | Group home | No | 10 |
| 10 | Group home | No | 44 |
| 11 | Group home | No | 17 |
| 12 | Group home | No | 4 |
| 13 | Group home | No | 28 |

[1] Foster home investigation records indicated whether the investigator considered a licensee's past valid licensing complaints, including which licensing complaints they considered, whereas group home investigation documents did not contain this information.

[2] We reviewed the number of licensing complaints that were listed in Guardian as "valid" and/or had a "letter of violation" disposition. We also reviewed all licensing complaints associated with the child welfare agency that operated the group home associated with each of the 6 validated group home licensing complaints.

Source: Auditor General staff review of investigation reports and other documents provided by the Department and information in Guardian for the 30 sampled licensing complaints.

## Issue 3: Department did not perform any ongoing monitoring of 35 group homes and other child welfare agency facilities during time we reviewed

Despite the Department's rules requiring it to monitor the ongoing activities of child welfare agencies, including group homes, our review of 35 licensed child welfare agency administrative offices and associated group homes found that the Department had not conducted any ongoing monitoring activities for these facilities from January 1, 2022 through April 30, 2023 (see Introduction, page 4, for additional information about the

Department's monitoring requirements).[35,36,37] According to NSAA best practices, ongoing monitoring should include periodic unannounced visits to licensed entities.[38] Rather than performing ongoing monitoring to help ensure licensees remain in compliance with licensure standards and that children are living in secure and healthy environments, the Department reported that the staff would visit many facilities as part of licensing complaint investigations or license renewal visits.[39] In April 2023, during our audit, the Department developed a checklist for staff to use during unannounced monitoring visits to child welfare agencies/group homes, and in May 2023, we observed the Department conduct site visits at 2 group homes from the 35 facilities we reviewed. Additionally, the Department reported in June 2023 that it plans to begin conducting quarterly monitoring of all child welfare agencies and associated facilities.

## Four factors contributed to Department problems with licensed foster home and group home licensing complaint investigations and enforcement, and ongoing monitoring of group homes

Our review of the 30 complaints, including 13 Department-validated licensing complaints, 35 licensed child welfare agencies/group homes, as well as our review of Department documents and interviews with Department management, supervisors, and caseworkers, identified 4 factors that contributed to the Department's problems with foster home and group home licensing complaint investigations and enforcement, as well as its lack of ongoing monitoring of the group homes we reviewed. Specifically, we found a Department culture of not wanting to take an enforcement-minded approach, including required enforcement action, in part because of Department concerns that this would reduce the number of facilities available to place children who are in the Department's care, which has contributed to its licensing complaint enforcement problems. We identified 3 additional factors that contributed to the Department's licensing complaint investigation and enforcement problems and its lack of ongoing monitoring of group homes: a lack of key data fields and other information in Guardian; a lack of policies, procedures, and time frames to guide various parts of the Department's licensing complaint investigation and enforcement processes and ongoing monitoring; and a lack of supervisory review and oversight of these processes and ongoing monitoring.

**Factor 1: The Department's culture of not wanting to take punitive enforcement action against its foster homes and group homes has contributed to foster home and group home licensing complaint enforcement problems—**As mentioned previously (see textbox on page 13), the Department is authorized by its rules to suspend or revoke a foster home license, a child welfare agency license, and a group home operating certificate; and to convert a child welfare agency license to provisional status. However, as of September 3, 2023, for the 2,711 closed foster home and group home licensing complaints documented in Guardian since February 2021, the Department has never documented changing to provisional status, suspending, or revoking a child welfare agency license or group home operating certificate, and has documented 30 licensing complaints for which the Department revoked the foster home license. In addition, the former Department director reported the Department did not want its enforcement actions to be punitive and stated a preference for working with facilities to remediate issues rather than closing them when testifying during the September 29, 2022, meeting of the Joint Legislative Oversight Committee on the

[35] The Department reported it did not conduct monitoring for 1 of these 35 group homes because the group home never received any children.

[36] We selected a sample of administrative offices and facilities operated by the 85 child welfare agencies licensed as of March 29, 2023. Specifically, we selected a random sample of 30 of 296 child welfare agency administrative offices and associated group home or shelter facilities and judgmentally selected an additional 5 of the remaining 266 facilities to review as follows: 1 facility that is not contracted with the Department, 1 facility for children with significant trauma, and 3 facilities with a history of licensing complaints (see Appendix A, page a-1, for additional information about our sample).

[37] Licensed child welfare agencies must apply for an operating certificate for each residential group home or shelter facility the agency plans to operate separate from its administrative offices. See AAC R6-5-7409 and 7410. The Department reported it should conduct monitoring activities at any facilities associated with a child welfare agency, including group homes and administrative offices, and that its reviews of administrative offices focus on whether an agency is safeguarding its records and confidential information.

[38] NSAA, 2004.

[39] Child welfare agency licenses are valid for 1 year before the licensee must apply for renewal.

Department of Child Safety. Further, during the audit, current Department management expressed concerns that punitive enforcement could lead to retention issues with licensees.

Further, based on conversations with Department staff, not all staff may have known that an individual group home operating certificate could be suspended or revoked separate from doing so to the child welfare agency's license; instead, at least some staff thought only a child welfare agency license could be suspended or revoked, impacting all the facilities attached to it. Thus, staff explained that it was easier for them to revoke a foster home license because it was issued to 1 individual, thereby impacting fewer children, whereas a child welfare agency license may have multiple facilities attached to it, thereby impacting many children, which gave them pause when considering whether to suspend or revoke the license. Additionally, until November 2022, the Department had only 1 staff person responsible for processing foster home license suspensions and revocations, which the Department reported is a time-consuming process. Further, as of March 2023, the Department reported it had 4 staff who handle foster home license suspensions and revocations.

Finally, although the Department has developed a matrix with graduated enforcement actions for validated child welfare agency/group home licensing complaints, it has not done so for foster home licensing complaints. Additionally, the Department's enforcement action matrix does not include the option to convert a child welfare agency license to provisional status, as authorized by rule, and allows for other enforcement actions in response to a validated licensing complaint, such as issuing a letter of concern to a licensee, that are not authorized by rule. The Department's rules for child welfare agency/group home licensing complaint-handling and enforcement have not been updated since 1997 and limit the Department's ability to implement graduated sanctions to respond to a range of potential child welfare agency/group home licensing complaints.[40]

**Factor 2: Guardian lacks key data fields and other information needed to track and monitor licensing complaint investigation and enforcement time frames—**Guardian data limitations have contributed to the Department's foster home and group home licensing complaint investigation and enforcement problems. Specifically:

- **Guardian's lack of key data fields makes it difficult for Department staff to monitor foster home and group home licensing complaints or take effective enforcement action—**Guardian lacks multiple data fields for staff to record key investigation and enforcement dates, including the investigation start date, the investigation completion date, and the enforcement action date.[41] Without these dates, Department staff cannot use Guardian to track the status of foster home and group home licensing complaints assigned to them, and Department supervisors and management cannot use Guardian to monitor whether licensing complaint investigations and enforcement actions are timely.

- **Problems with staff data entry in Guardian make it difficult for Department staff to use Guardian to monitor foster home and group home licensing complaints or take effective enforcement action—**Specifically:

    - The Department may address different licensing complaints related to the same licensee at the same time, but in doing so may not document clearly in Guardian what allegations should be investigated. For example, for the previously mentioned group home licensing complaint on pages 10 and 11, the Department had combined a licensing complaint alleging that a group home employee had hugged a child and touched the child's face against the child's will with its licensing complaint related to bruising found on the same child, but never documented investigating the bruising allegations.

    - Additionally, Guardian contains some duplicate licensing complaint entries because of multiple calls to the Department hotline for a single allegation that have not been combined and because of

[40] On January 13, 2023, the Department filed a notice of proposed rulemaking for child placing and child welfare agency rules, and on September 6, 2023, the Governor's Regulatory Review Council approved the rules. The Department reported it anticipates the rules will become effective on November 6, 2023.

[41] Because of these missing dates in Guardian, to perform our timeliness analysis, we obtained the dates from investigation and enforcement documents.

investigation staff manually creating an entry in Guardian before the licensing complaint became visible on the investigation dashboard for some licensing complaints impacted by a software issue (see discussion below for additional information).[42] Multiple entries for a single licensing complaint could lead to some information being recorded in 1 entry and some other information being recorded in the other entry, resulting in no complete licensing complaint or resolution entry in Guardian.

- **Guardian software issue resulted in some foster home and group home licensing complaints not appearing assigned to investigators in Guardian although they had been, impacting investigation timeliness—**The Department reported that a software issue in Guardian caused some foster home and group home licensing complaints to not appear on the assigned investigators' dashboards in Guardian, which delayed the start of the investigations. Specifically, the Department reported that this software issue resulted in at least 199 foster home and group home licensing complaints appearing unassigned in Guardian for up to hundreds of days, including 3 licensing complaints we reviewed (see Figure 2, page 9). The Department reported that this software issue has since been resolved.

According to the Department, it is exploring whether other IT systems could enhance its licensing complaint-handling process and will determine the best option to track and monitor this process.

**Factor 3: The Department lacked written policies, procedures, and time frames to guide key parts of its foster home and group home licensing complaint investigations and enforcement processes and ongoing monitoring of group homes, but developed written procedures for some aspects of its licensing complaint-handling and monitoring process after our review—**The Department's lack of key policies, procedures, and/or time frames contributed to the Department's problems with its licensing complaint investigations and enforcement and ongoing monitoring; however, since our review, the Department developed some written procedures related to aspects of its licensing complaint-handling and monitoring process. Specifically:

- **Department has not developed and implemented time frames for completing each of the key steps in its foster home and group home licensing complaint process—**As shown in Figure 1 in the Introduction (see pages 5 and 6), the Department's licensing complaint investigation and enforcement processes include numerous steps and, depending on whether the licensing complaint is about a foster home or child welfare agency/group home, and is regarding abuse/neglect or a licensing violation, it goes through different steps. However, the Department has not developed and implemented time frames for each of the steps in its process. For example, the Department has not taken into account hotline staff's time to assign licensing complaints to OLR investigators as part of the Department's licensing complaint investigation time frames.[43] For the 28 licensing complaints we reviewed in our sample of 30 foster home and group home complaints, it took hotline staff a median of 5.5 days to assign an investigation to OLR. Further, for 4 of 28 licensing complaints we reviewed, hotline staff had taken between 4 and 18 days to assign the licensing complaints for investigation and the Department did not take these days into consideration when establishing its overall investigation time frames. As a result, although OLR investigators completed their investigations within 45 days, the time these licensing complaints were with hotline staff contributed to the Department not ensuring these complaint investigations were completed within 45 days after receipt of the complaint. Additionally, the Department has not developed and implemented time frames for steps staff should take when taking enforcement action in response to all validated licensing complaints, such as developing a corrective action plan or preparing to revoke a license. Formalizing these timeliness standards in policy demonstrates their importance to staff, foster homes and group homes, and stakeholders, and enables the Department to monitor and hold staff accountable for meeting them.

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[42] One common reason for a duplicate investigation entry is that when a licensing complaint was affected by a software issue, staff might become aware of it before it appeared on their dashboard and manually create an investigation entry to begin work on the licensing complaint, but the licensing complaint affected by the software issue was also eventually added to the investigation dashboard, leaving 2 entries of the same licensing complaint in Guardian.

[43] According to the Department, it intends to hire staff to conduct foster home licensing complaint investigations and remove this responsibility from its contracted licensing agencies beginning in February 2024.

- **Department has not followed its policies, procedures, or time frames for ongoing monitoring of group homes, and has begun revising its procedures—**During the time frame of our review, although the Department had a policy and procedures for conducting quarterly monitoring activities for group homes, some Department staff reported they were unaware of this policy. Additionally, Department management reported that it had stopped conducting ongoing monitoring activities during the time frame of our review to reassess its monitoring processes. The Department also reported that it previously had staff dedicated to the ongoing monitoring of child welfare agencies and group homes, but now these staff must also make time for other responsibilities, such as investigating licensing complaints and processing license applications. To help address limitations on staff resources, NSAA best practices indicate that agencies should establish a schedule for regularly monitoring regulated entities that is frequent enough to provide reasonable safeguards to the public and risk-based, if possible (see next bullet for details on risk-based prioritization).[44] As of April 2023, the Department had begun to develop new procedures for conducting group home monitoring and had developed a checklist for staff to use during unannounced group home site visits. However, the Department had not developed associated written guidance or instructions outlining who is responsible for ongoing monitoring, how to select facilities for monitoring and complete the site visits checklist, and the frequency of unannounced site visits.

- **Department does not have policies and procedures to guide staff on risk-based prioritization for foster home and group home licensing complaint investigations—**Although best practices and guidance indicate that agencies should use risk-based prioritization for licensing complaint investigations, the Department has not done so, which may have contributed to the most concerning licensing complaints not being investigated and requisite enforcement action taken in a timely manner. Specifically, NSAA best practices indicate that agencies should prioritize investigations based on the risk associated with a licensing complaint allegation.[45] Similarly, a 2018 report from the United States Department of Health and Human Services (HHS) includes guidance that applicable state agencies should prioritize investigating licensing complaints involving serious allegations such as physical abuse, deaths, or potentially life-threatening or serious injuries or illnesses.[46] Since the time of our licensing complaint review, the Department has drafted written procedures with time frames for prioritizing and initiating investigations as soon as 5 days and no later than 30 days depending on the risk associated with the allegation, but it has not implemented these time frames. Further, the Department's draft procedures lack necessary guidance, such as the criteria or types of allegations that would fall under each prioritization level. For example, as discussed in the Introduction (see page 4), the Department reported that as of June 30, 2023, it would no longer investigate allegations of abuse against child welfare agency staff and would forward these allegations to law enforcement while concurrently opening a licensing complaint investigation related to the child welfare agency that employs the individual, but the Department's draft procedures do not indicate if these types of complaints would be considered high priority. The draft procedures also lack requirements for documenting the prioritization level, such as recording it in Guardian; and the actions/activities that an investigation initiation comprises.

- **Department lacks some procedures to guide staff regarding interviewing staff and children residing at foster homes and group homes—**The Department's lack of written procedures specifying if or when to interview the individuals involved in a licensing complaint allegation, including children who were the subject of the licensing complaint, likely contributed to the Department's incomplete investigations. The Department has since developed draft procedures requiring investigators to interview children affected by the allegation and other children if deemed appropriate, but the Department does not have guidance for determining when children should or should not be interviewed, including when there is a risk of

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[44] NSAA, 2004.

[45] NSAA, 2004.

[46] United States Department of Health and Human Services Office of Inspector General, Administration for Community Living, and Office for Civil Rights. (2018). *Joint report: Ensuring beneficiary health and safety in group homes through state implementation of comprehensive compliance oversight*. Washington, DC. Retrieved 7/6/2023 from https://www.oig.hhs.gov/reports-and-publications/featured-topics/group-homes/group-homes-joint-report.pdf. This report reviewed states' investigations of incidents involving developmentally disabled group home residents, but the general principles of its guidance can be applied to other vulnerable populations such as foster children.

retraumatizing the children, and how sufficient information can be obtained if not all individuals involved in the licensing complaint can be interviewed. Further, the Department has not implemented the draft procedures; therefore, the Department is not following them, and staff are not accountable for complying with them.

- **Department lacks procedures for working with law enforcement on concurrent investigations of group home staff—**As discussed in the Introduction (see page 4), the Department reported that as of June 30, 2023, it would no longer investigate allegations of abuse against child welfare agency staff and would forward these allegations to law enforcement while concurrently opening a licensing complaint related to the child welfare agency that employs the individual. However, the Department has not developed written policies and procedures to guide staff on when and how to work with law enforcement when conducting these licensing complaint investigations of child welfare agency staff. For example, the Department lacks procedures outlining whether, when, and how its staff should work with law enforcement to share information and/or coordinate licensing complaint investigations with law enforcement personnel to avoid interfering with law enforcement's investigations. Additionally, although the Department has draft procedures that require OLR to resolve a complaint that a Department child abuse/neglect investigator has investigated within 21 days after receiving an abuse or neglect investigation report, the draft procedures do not include a similar requirement or related guidance related to reviewing and taking action as a result of law enforcement investigations of abuse and neglect involving child welfare agency staff.

- **Department lacks procedures to guide staff regarding researching foster home and group home licensing complaint history—**Although the Department has procedures indicating its staff should consider licensees' history of prior violations when determining enforcement actions for validated foster home and group home licensing complaints, it lacks additional procedures or guidance to direct staff how to research licensing complaint history. For example, according to the Department, many of its historical licensing complaint investigation records are not stored in Guardian, but the Department lacks guidance for how staff should locate and/or access these records.

**Factor 4: The Department lacks procedures for supervisory reviews or monitoring to ensure its foster home and group home licensing complaint investigations and enforcement actions and ongoing monitoring of group homes is being performed timely, effectively, and as required—**Although the Department has procedures requiring supervisors to review foster home investigations to ensure all children/adults were interviewed and to review a foster home's licensing complaint history, it lacks similar guidance for group homes, which may help explain why we found that the Department had considered a licensee's licensing complaint history when taking enforcement actions in response to foster home licensing complaints we reviewed but not for group home licensing complaints we reviewed (see pages 14 and 15 for additional information about this issue).

Further, the Department lacks written procedures for supervisory review, monitoring, and tracking of the Department's other responsibilities related to both foster home and group home licensing complaint investigations and enforcement actions, and ongoing group home monitoring activities, contributing to the Department's problems we identified in carrying out these responsibilities. For example, although the Department provided a spreadsheet that it reported supervisors use to oversee staff's completion of licensing complaint-handling steps, the spreadsheet lacks any associated procedures, guidance, or instructions to indicate who is responsible for using the spreadsheet and when and how they would use it. Without written procedures for supervisory review, monitoring, and oversight, the Department may be unaware if staff are performing investigations timely and effectively, enforcement actions are sufficient, and ongoing group home monitoring is occurring.

## Recommendations

To ensure foster home and child welfare agency/group home licensing complaint investigations and enforcement actions are timely and effective and ongoing group home monitoring is performed, the Department should:

1. Further develop and implement its draft licensing complaint-handling procedures to include time frames for each key foster home and/or group home licensing complaint investigation and enforcement step, including time frames for assigning licensing complaints for investigation and taking action in response to validated licensing complaints, and complete licensing complaint investigations and take enforcement actions consistent with these time frames.
2. Further revise and implement its draft guidance for taking a risk-based approach to prioritize foster home and group home licensing complaint investigations by specifying which types of allegations correspond to each prioritization level, including licensing complaint investigations opened in response to abuse/neglect allegations related to child welfare agency staff, staff requirements for documenting the prioritization level, and what actions/activities staff should take to initiate an investigation.
3. Further revise and/or develop procedures for interviewing staff and children residing at foster homes and group homes during licensing complaint investigations, including guidance for determining when children should or should not be interviewed.
4. Develop and implement written guidance for staff to work with law enforcement when conducting licensing complaint investigations opened in response to abuse/neglect allegations related to child welfare agency staff, including how its staff should work with law enforcement to share information and/or coordinate licensing complaint investigations with law enforcement personnel and when and how its staff should review the results of law enforcement investigations.
5. Revise and/or develop and implement written guidance for staff to research foster home and group home licensee violation history.
6. Revise and/or adopt new rules for child welfare agency licensing complaint handling, as necessary, to authorize a greater range of enforcement actions.
7. Consistent with the Department's rules revised in recommendation 6, update and implement the Department's graduated system of enforcement actions for validated child welfare agency/group home licensing complaints and include guidance for staff specifying the violations that would lead to different enforcement actions, including mitigating and/or aggravating factors staff should consider.
8. Develop and implement a graduated system of enforcement actions for validated foster home licensing complaints and include guidance for staff specifying the violations that would lead to different enforcement actions, including mitigating and/or aggravating factors staff should consider.
9. Further develop and implement policies and procedures regarding ongoing monitoring of group homes, including assigning staff responsibility for conducting ongoing monitoring, outlining how to select facilities for monitoring and complete the site visits checklist, and specifying the frequency of site visits and providing guidance for risk-based and unannounced site visits; and perform ongoing monitoring consistent with the policies and procedures.
10. Add data fields to Guardian and/or another IT system for key dates in the licensing complaint-handling process, including the investigation start date, the investigation completion date, and the enforcement action date.
11. Develop and implement a method in Guardian and/or another IT system to combine multiple licensing complaints it receives for the same licensee into the same licensing complaint entry, including combining relevant details from each entry; and develop monitoring reports to keep track of these licensing complaints that have been combined.

12. Require tracking, supervisory review, and managerial oversight of the licensing complaint investigation and enforcement processes and regular ongoing group home monitoring to verify staff compliance with Department policies, procedures, and time frames. Add reporting capabilities to Guardian and/or another IT system, as necessary, to help Department staff track, review, and oversee these processes.

**Department response:** As outlined in its **response**, the Department agrees with the finding and will implement or implement in a different manner the recommendations.

## Auditor General makes 12 recommendations to the Department

To ensure foster home and child welfare agency/group home licensing complaint investigations and enforcement actions are timely and effective and ongoing group home monitoring is performed, the Department should:

1. Further develop and implement its draft licensing complaint-handling procedures to include time frames for each key foster home and/or group home licensing complaint investigation and enforcement step, including time frames for assigning licensing complaints for investigation and taking action in response to validated licensing complaints, and complete licensing complaint investigations and take enforcement actions consistent with these time frames (see Finding 1, pages 7 through 22, for more information).

2. Further revise and implement its draft guidance for taking a risk-based approach to prioritize foster home and group home licensing complaint investigations by specifying which types of allegations correspond to each prioritization level, including licensing complaint investigations opened in response to abuse/neglect allegations related to child welfare agency staff, staff requirements for documenting the prioritization level, and what actions/activities staff should take to initiate an investigation (see Finding 1, pages 7 through 22, for more information).

3. Further revise and/or develop procedures for interviewing staff and children residing at foster homes and group homes during licensing complaint investigations, including guidance for determining when children should or should not be interviewed (see Finding 1, pages 7 through 22, for more information).

4. Develop and implement written guidance for staff to work with law enforcement when conducting licensing complaint investigations opened in response to abuse/neglect allegations related to child welfare agency staff, including how its staff should work with law enforcement to share information and/or coordinate licensing complaint investigations with law enforcement personnel and when and how its staff should review the results of law enforcement investigations (see Finding 1, pages 7 through 22, for more information).

5. Revise and/or develop and implement written guidance for staff to research foster home and group home licensee violation history (see Finding 1, pages 7 through 22, for more information).

6. Revise and/or adopt new rules for child welfare agency licensing complaint handling, as necessary, to authorize a greater range of enforcement actions (see Finding 1, pages 7 through 22, for more information).

7. Consistent with the Department's rules revised in recommendation 6, update and implement the Department's graduated system of enforcement actions for validated child welfare agency/group home licensing complaints and include guidance for staff specifying the violations that would lead to different enforcement actions, including mitigating and/or aggravating factors staff should consider (see Finding 1, pages 7 through 22, for more information).

8. Develop and implement a graduated system of enforcement actions for validated foster home licensing complaints and include guidance for staff specifying the violations that would lead to different enforcement actions, including mitigating and/or aggravating factors staff should consider (see Finding 1, pages 7 through 22, for more information).

9. Further develop and implement policies and procedures regarding ongoing monitoring of group homes, including assigning staff responsibility for conducting ongoing monitoring, outlining how to select facilities for monitoring and complete the site visits checklist, and specifying the frequency of site visits and providing guidance for risk-based and unannounced site visits; and perform ongoing monitoring consistent with the policies and procedures (see Finding 1, pages 7 through 22, for more information).

10. Add data fields to Guardian and/or another IT system for key dates in the licensing complaint-handling process, including the investigation start date, the investigation completion date, and the enforcement action date (see Finding 1, pages 7 through 22, for more information).

11. Develop and implement a method in Guardian and/or another IT system to combine multiple licensing complaints it receives for the same licensee into the same licensing complaint entry, including combining relevant details from each entry; and develop monitoring reports to keep track of these licensing complaints that have been combined (see Finding 1, pages 7 through 22, for more information).

12. Require tracking, supervisory review, and managerial oversight of the licensing complaint investigation and enforcement processes and regular ongoing group home monitoring to verify staff compliance with Department policies, procedures, and time frames. Add reporting capabilities to Guardian and/or another IT system, as necessary, to help Department staff track, review, and oversee these processes (see Finding 1, pages 7 through 22, for more information).

## Scope and methodology

The Arizona Auditor General has conducted this performance audit of the Department pursuant to a December 17, 2020, resolution of the Joint Legislative Audit Committee. The audit was conducted as part of the sunset review process prescribed in A.R.S. §41-2951 et seq.

We used various methods to address the audit's objectives. These methods included reviewing applicable State statutes and rules, the Department's policies and procedures, information from the Department's website and stored in Guardian; and interviewing Department staff. In addition, we used the following specific methods to meet the audit objectives:

- To determine whether the Department timely investigated and took enforcement action in response to child welfare agency and foster home licensing complaints it received, we reviewed a stratified random sample of 30 of 1,389 foster home and group home complaints the Department received and documented in Guardian in calendar year 2022 and that the Department had resolved as of March 20, 2023.[47,48] We also reviewed draft procedures the Department developed in January 2023 related to licensing complaint investigations.

- To determine whether the Department conducted ongoing monitoring of group homes as required by Department rules, we reviewed a sample of 35 of 296 child welfare agency administrative offices and associated group homes operated by child welfare agencies actively licensed as of March 29, 2023, and requested documentation of any ongoing monitoring activities the Department conducted at these facilities between January 1, 2022 and June 1, 2023.[49,50] We also observed 4 group home site visits that the

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[47] We selected a stratified random sample of 15 of 666 foster home and group home complaints for which the Department documented taking no further action in response to the complaint; and 15 of 723 complaints for which the Department documented taking some action, such as requiring a corrective action plan. Further, our sample included 8 foster home and 7 group home complaints for which the Department documented taking some action, and 5 foster home and 10 group home complaints for which the Department documented taking no further action. Finally, our sample included 28 licensing complaints OLR or a licensing agency investigated and 2 allegations of abuse or neglect for which OLR reviewed the investigation findings; as such, we removed the 2 allegations of abuse or neglect from our analysis of the timeliness of OLR's licensing complaint investigations.

[48] We found several data reliability issues with the Department's licensing complaint investigations portal in Guardian, including that Guardian does not include data fields to record an investigation start date, the investigation completion date, or the date of any enforcement action taken in response to a licensing complaint; and that some data fields are not consistently filled in, such as whether a licensing complaint was validated. Additionally, the population of complaints we reviewed may be inaccurate because of duplicate complaint entries we identified. Despite these limitations, we were able to use other sources of information, such as investigation records, to obtain information and data that was not in Guardian, and our sample of complaints still provides sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions related to the Department's licensing complaint-handling processes.

[49] We selected a sample of administrative offices and facilities operated by the 85 child welfare agencies licensed as of March 29, 2023. Specifically, we selected a random sample of 30 of 296 child welfare agency administrative offices and associated group home or shelter facilities and judgmentally selected an additional 5 of the remaining 266 facilities to review as follows: 1 facility that is not contracted with the Department, 1 facility for children with significant trauma, and 3 facilities with a history of licensing complaints.

[50] As of March 29, 2023, the Department reported its 85 licensed child welfare agencies operated the following 296 facilities: 34 standalone administrative offices, 48 group homes or shelters located at the child welfare agency's administrative offices, and 214 standalone group homes or shelters. Our random sample of 30 of 296 facilities included 3 standalone child welfare agency administrative offices, 5 group homes and 1 shelter located at the agency administrative offices, and 20 standalone group homes and 1 standalone shelter. For reporting purposes, we refer to all facilities operating under a child welfare agency license as "group homes."

Department conducted in May and June 2023.[51]

- To determine whether the Department's licensing complaint-handling and monitoring practices were consistent with recommended practices, we reviewed recommended practices from CWLA, HHS, and NSAA.[52]

- To obtain additional information for the Introduction, we reviewed the Department's June 2023 *Monthly Operational and Outcome Report*.

Our work on internal controls included reviewing the Department's policies and procedures for ensuring compliance with statute and rule, and, where applicable, testing its compliance with these policies and procedures. We reported our conclusions on internal control deficiencies in Finding 1.

We selected our audit samples to provide sufficient evidence to support our findings, conclusions, and recommendations. Unless otherwise noted, the results of our testing using these samples were not intended to be projected to the entire population.

We conducted this performance audit of the Department in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

We express our appreciation to the Department Director and staff for their cooperation and assistance throughout the audit.

[51] We judgmentally selected 5 of the 11 unannounced group home site visits the Department scheduled between May 15 and June 7, 2023, all of which were located in Maricopa County, to include group homes that met at least 1 of the following criteria: were not contracted with the Department, had a history of licensing complaints, were part of a larger network of group homes operated by 1 child welfare agency, and/or served children with special needs such as teen parents. Additionally, we selected site visits for which a different caseworker was assigned to complete each visit. Although we were ultimately able to observe only 3 of these site visits, we attended the CEO debrief for a fourth site visit and observed a fifth site visit for a group home not included in our original sample held on June 16, 2023, for a total of 4 site visits and 1 CEO debrief.

[52] Child Welfare League of America (CWLA). (2003). *CWLA best practice guidelines: Child maltreatment in foster care*. Washington, DC. Retrieved 7/6/2023 from https://www.hunter.cuny.edu/socwork/nrcfcpp/downloads/policy-issues/maltreatment-guidelines.pdf; National State Auditors Association (NSAA). (2004). *Carrying out a state regulatory program: A National State Auditors Association best practices document*. Lexington, KY. Retrieved 3/15/2023 from https://www.nasact.org/files/News_and_Publications/White_Papers_Reports/NSAA%20Best%20Practices%20Documents/2004_Carrying_Out_a_State_Regulatory_Program.pdf; United States Department of Health and Human Services Office of Inspector General, Administration for Community Living, and Office for Civil Rights. (2018). *Joint report: Ensuring beneficiary health and safety in group homes through state implementation of comprehensive compliance oversight.* Washington, DC. Retrieved 7/6/2023 from https://www.oig.hhs.gov/reports-and-publications/featured-topics/group-homes/group-homes-joint-report.pdf. The 2018 HHS joint report reviewed states' investigations of incidents involving developmentally disabled group home residents, but the general principles of its guidance can be applied to other vulnerable populations such as foster children.

# DEPARTMENT RESPONSE

David Lujan, Cabinet Executive Officer/Executive Deputy Director
Katie Hobbs, Governor

September 27, 2023

Lindsey Perry, CPA, CFE
Auditor General
Arizona Office of the Auditor General
2910 North 44th Street, Suite 410
Phoenix, Arizona 85018

RE: Auditor General's report, *Arizona Department of Child Safety – Licensed Foster Care Provider Oversight*

Dear Ms. Perry:

The Arizona Department of Child Safety (Department) has reviewed the Auditor General's report, *Arizona Department of Child Safety – Licensed Foster Care Provider Oversight.* The Department agrees that improvements can be made to processes for investigating, taking enforcement action and ongoing monitoring of licensed out-of-home care providers. The response to the findings and recommendations are enclosed.

The Department appreciates your consideration of our feedback and revisions made to the report.

Sincerely,

David Lujan
Cabinet Executive Officer/Executive Deputy Director

Enclosure: DCS Recommendation Response



P.O. Box 6030 ♦ Site Code C010-23 ♦ Phoenix, AZ 85005-6030
Telephone (602) 255-2500

**Finding 1**: Department problems related to investigating, taking enforcement action against, and monitoring licensed providers for children in out-of-home care could result in children being in risky or unhealty environments

To ensure foster home and child welfare agency/group home licensing complaint investigations and enforcement actions are timely and effective and ongoing group home monitoring is performed, the Department should:

**Recommendation 1:** Further develop and implement its draft licensing complaint-handling procedures to include time frames for each key foster home and/or group home licensing complaint investigation and enforcement step, including time frames for assigning licensing complaints for investigation and taking action in response to validated licensing complaints, and complete licensing complaint investigations and take enforcement actions consistent with these time frames.

Department response: The finding of the Auditor General is agreed to and the audit recommendation will be implemented.

Response explanation: The Department will develop and implement procedures or standard work for time frames for each key licensing complaint investigation and enforcement steps including assigning licensing complaints for investigation, taking action in response to validated licensing complaints and complete licensing complaint investigations. The Department also agrees to take enforcement actions consistent with these time frames

**Recommendation 2:** Further revise and implement its draft guidance for taking a risk-based approach to prioritize foster home and group home licensing complaint investigations by specifying which types of allegations correspond to each prioritization level, including licensing complaint investigations opened in response to abuse/neglect allegations related to child welfare agency staff, staff requirements for documenting the prioritization level, and what actions/activities staff should take to initiate an investigation.

Department response: The finding of the Auditor General is agreed to and the audit recommendation will be implemented.

Response explanation: The Department will develop guidance specific to the new rules effective in November 2023. The guidance will include: specifying which types of allegations correspond to each prioritization level, including licensing complaint investigations opened in response to abuse/neglect allegations related to child welfare agency staff, staff requirements for documenting the prioritization level, and what actions/activities staff should take to initiate an investigation.

**Recommendation 3:** Further revise and/or develop procedures for interviewing staff and children residing at foster homes and group homes during licensing complaint investigations, including guidance for determining when children should or should not be interviewed.

Department response: The finding of the Auditor General is agreed to and the audit recommendation will be implemented.

Response explanation: The Department will develop procedures and guidance for addressing licensing complaints. The procedures and guidance will include information identifying:

- when and if OLR staff should interview children
- when and if OLR staff should utilize existing interviews or documentation from the assigned DCS Specialist who has regular contact with the child(ren).

**Recommendation 4:** Develop and implement written guidance for staff to work with law enforcement when conducting licensing complaint investigations opened in response to abuse/neglect allegations related to child welfare agency staff, including how its staff should work with law enforcement to share information and/or coordinate licensing complaint investigations with law enforcement personnel and when and how its staff should review the results of law enforcement investigations.

Department response: The finding of the Auditor General is agreed to and the audit recommendation will be implemented.

Response explanation: The Department agrees to develop and implement written guidance for staff to work with law enforcement when conducting licensing complaint investigations opened in response to abuse/neglect allegations related to child welfare agency staff.

**Recommendation 5:** Revise and/or develop and implement written guidance for staff to research foster home and group home licensee violation history.

Department response: The finding of the Auditor General is agreed to and the audit recommendation will be implemented.

Response explanation: The Department acknowledges the importance of researching and understanding licensee violation history and if it indicates a pattern of behavior that needs further attention, the Department will develop and implement written guidance for staff.

**Recommendation 6:** Revise and/or adopt new rules for child welfare agency licensing complaint handling, as necessary, to authorize a greater range of enforcement actions.

Department response: The finding of the Auditor General is agreed to and the audit recommendation will be implemented.

Response explanation: The Department has been working on revising the rules for child welfare licensing since February 2015. These rules have been approved through public comment and the Governor's Regulatory Review Council (GRRC). The rules will be signed and become effective November 2023. The Department will implement policies and procedures to address expanding enforcement actions, as necessary.

**Recommendation 7:** Consistent with the Department's rules revised in recommendation 6, update and implement the Department's graduated system of enforcement actions for validated child welfare agency/group home licensing complaints and include guidance for staff specifying the violations that would lead to different enforcement actions, including mitigating and/or aggravating factors staff should consider.

Department response: The finding of the Auditor General is agreed to and the audit recommendation will be implemented.

Response explanation: The Department agrees to update and implement the graduated system of enforcement actions for validated child welfare agency/group home licensing complaints and include guidance specifying violations that lead to different enforcement actions.

**Recommendation 8:** Develop and implement a graduated system of enforcement actions for validated foster home licensing complaints and include guidance for staff specifying the violations

that would lead to different enforcement actions, including mitigating and/or aggravating factors staff should consider.

Department response: The finding of the Auditor General is agreed to and the audit recommendation will be implemented.

Response explanation: The Department agrees with the importance of enforcement actions for validated foster home licensing complaints. The Department will develop and implement a graduated system of enforcement actions for validated foster home licensing complaints and include guidance for staff specifying the violations that would lead to different enforcement actions.

**Recommendation 9:** Further develop and implement policies and procedures regarding ongoing monitoring of group homes, including assigning staff responsibility for conducting ongoing monitoring, outlining how to select facilities for monitoring and complete the site visits checklist, and specifying the frequency of site visits and providing guidance for risk-based and unannounced site visits; and perform ongoing monitoring consistent with the policies and procedures.

Department response: The finding of the Auditor General is agreed to and the audit recommendation will be implemented.

Response explanation: The Department recognizes the importance of ongoing announced and unannounced monitoring of group homes and will further develop and implement policies and procedures, as recommended.

**Recommendation 10:** Add data fields to Guardian and/or another IT system for key dates in the licensing complaint-handling process, including the investigation start date, the investigation completion date, and the enforcement action date.

Department response: The finding of the Auditor General is agreed to and a different method of dealing with the finding will be implemented.

Response explanation: The Department is exploring licensing systems to enhance and improve its work. The Department currently tracks the investigation start date, the investigation completion date and the enforcement action date in the Quick Connect licensing system and through other resources outside of Guardian. The Department will explore the best option to track the information.

**Recommendation 11:** Develop and implement a method in Guardian and/or another IT system to combine multiple licensing complaints it receives for the same licensee into the same licensing complaint entry, including combining relevant details from each entry; and develop monitoring reports to keep track of these licensing complaints that have been combined.

Department response: The finding of the Auditor General is agreed to and a different method of dealing with the finding will be implemented.

Response explanation: The Department is exploring licensing systems to enhance and improve its work. The Department will explore the best option to track the information and will evaluate if Guardian is the best place to consolidate the information.

**Recommendation 12:** Require tracking, supervisory review, and managerial oversight of the licensing complaint investigation and enforcement processes and regular ongoing group home

monitoring to verify staff compliance with Department policies, procedures, and time frames. Add reporting capabilities to Guardian and/or another IT system, as necessary, to help Department staff track, review, and oversee these processes.

Department response: The finding of the Auditor General is agreed to and a different method of dealing with the finding will be implemented.

Response explanation: The Department will evaluate the best methods for tracking, supervisory review and managerial oversight of the licensing complaint investigation and enforcement processes and regular ongoing group home monitoring to ensure compliance with any newly developed procedures or standard work. The Department will explore the options to track the information and will evaluate if Guardian is the best option.

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