### **Report in Brief**

Date: December 2017 Report No. A-01-16-02500

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

#### Why OIG Did This Review

Congress has expressed concerns about the safety and well-being of children in foster care. These issues were highlighted in a media report that provided several examples of children who died while in foster care. To determine whether health and safety vulnerabilities exist, we are performing reviews of foster care group homes in several States, including Massachusetts. In Massachusetts, the Department of Children and Families is responsible for administering the Title IV-E foster care program.

Our objective was to determine whether Massachusetts' monitoring ensured that foster care group homes complied with State licensing requirements related to the health and safety of children in foster care.

#### **How OIG Did This Review**

Of the 101 group home locations in Massachusetts that received foster care Title IV-E funding for calendar year 2015, we selected 30 homes for our review. We selected these group homes on the basis of various factors, including the group homes' location, capacity, age of the children in the homes, and operational status. We conducted unannounced site visits throughout Massachusetts in May 2016.

## Some Massachusetts Group Homes for Children in Foster Care Did Not Always Comply With State Health and Safety Requirements

#### What OIG Found

Although the Department of Early Education and Care (State licensing agency) performed the required onsite monitoring at all 30 of the group homes that we reviewed, this onsite monitoring did not ensure that all 30 homes complied with State licensing requirements related to the health and safety of children in foster care. Specifically, at the time of our onsite visits, with regards to facilities and equipment, we found that 27 group homes did not comply with 1 or more State requirements for living units, 26 group homes did not comply with 1 or more State requirements for buildings and grounds, 20 group homes did not comply with 1 or more State requirements related to bathing and toilet facilities, and 11 group homes did not comply with 1 or more State requirements related to toxic substances. In addition, we found that 15 group homes did not comply with State requirements regarding the care of residents, and 18 group homes did not comply with 1 or more required background records check or fingerprint submission requirements for employees. Because Massachusetts did not ensure that group homes complied with State requirements, the health and safety of the children residing in the group homes were potentially at risk.

#### **What OIG Recommends and State Comments**

We recommend that Massachusetts (1) work with the State licensing agency to ensure all instances of noncompliance are corrected, (2) consider adding a requirement in future contracts that the group homes conduct repairs and general upkeep within a specified timeframe, (3) increase the frequency of announced visits and consider including unannounced visits as part of its monitoring system, and (4) work with the State licensing agency to implement adequate monitoring controls to ensure that all group home employees who have the potential for unsupervised contact with children in foster care receive all of the required background record checks within a specific and reasonable timeframe.

In written comments on our draft report, Massachusetts concurred with our first, third, and fourth recommendations, and it said that it will take our second recommendation into consideration for future contracts. In addition, Massachusetts outlined corrective actions and improved collaboration with the State's Department of Early Education and Care to address our findings and recommendations.