Report in Brief

Date: October 2018 Report No. A-05-17-00030

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

Why OIG Did This Review

We conducted health and safety reviews of Head Start grantees, regulated childcare facilities, and family adult foster care homes in Minnesota. The reviews in Minnesota identified multiple health and safety issues, and we chose the Family Care program (the program) to determine whether there may be similar health and safety risks affecting vulnerable adults receiving services in Wisconsin certified adult day care centers (centers). The program funds home and community-based services, such as services received at a center, for older family members and for adults with physical or developmental disabilities.

Our objective was to determine whether Wisconsin complied with Federal waiver and State requirements in overseeing centers that serve vulnerable adults who receive services through the program.

How OIG Did This Review

Of the 126 centers in Wisconsin where vulnerable adults received services through the program for the quarter ended December 2016, we selected 20 centers for our review. We selected the centers on the basis of their geographic location, capacity, and history of health- and safety-related violations identified by the State. We conducted 19 unannounced site visits and 1 announced visit from July 26 through October 18, 2017.

Wisconsin Did Not Comply With Federal Waiver and State Requirements at All 20 Adult Day Service Centers Reviewed

What OIG Found

Wisconsin did not comply with Federal waiver and State requirements in overseeing centers that serve vulnerable adults who receive services through the program. All 20 of the centers we reviewed did not comply with State certification requirements. In total, we found 208 instances of noncompliance with health and safety and administrative requirements.

Wisconsin said that instances of noncompliance occurred partly because of low staffing levels that did not allow State surveyors to make recertification visits every 2 years. Additionally, Wisconsin officials confirmed that the certification checklist was outdated and lacked clarity on certain requirements, and certification requirements were not in the Wisconsin Administrative Rules. Wisconsin also said that there was minimal attendance by center personnel at State- or trade association-sponsored voluntary training programs. Finally, center personnel indicated the need for improved State agency communication and more guidance related to the specific center certification requirements.

What OIG Recommends and Wisconsin Comments

We recommend that Wisconsin (1) ensure that the 208 instances of noncompliance with health and safety and administrative requirements identified in this report are corrected, (2) consider revising staffing standards and caseload thresholds for State surveyors, (3) update the certification checklist and promulgate rules as required by Wisconsin Statutes, (4) identify and address reasons for low attendance by center personnel at training programs, and (5) increase State agency guidance related to center requirements.

Wisconsin partially concurred with our first two recommendations and concurred with our remaining three recommendations. We maintain that our findings and recommendations remain valid. Regarding our recommendation to ensure instances of noncompliance are corrected, we noted that all 12 centers where knives or chemicals were accessible served populations with medical conditions (e.g., dementia or developmental disability) that could pose a danger to themselves or others. Regarding our recommendation to consider revising staffing standards, 8 of the 20 centers with substantial instances of noncompliance had their last State agency inspection at least 2 years before our visits. More frequent inspections by additional staff would likely decrease the instances of noncompliance.