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

Some Oklahoma Group Homes Did Not Always Comply With State Requirements

Why OIG Did This Review

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

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

How OIG Did This Review

Using the minimum standards required by the Oklahoma Administrative Code, we created a health and safety checklist, reviewed background check supporting documentation, and conducted site visits on all 22 foster care group homes in Oklahoma. After each site visit, we informed the group homes' management of any issues found during our visit. Additionally, upon completion of our review of all the group homes, we provided Oklahoma with a summary of all issues found during our review.

What OIG Found

Although Oklahoma performed the required onsite monitoring at all 22 group homes, this onsite monitoring did not ensure that foster care group homes complied with State licensing and Federal requirements related to the health and safety of children in foster care. We determined that 17 of the 22 group homes did not comply with 1 or more State health and safety requirements. Specifically, we found that 12 of the group homes did not comply with transportation requirements; 12 of the group homes did not comply with building, utilities, and grounds requirements; 10 of the group homes did not comply with fire safety requirements; 4 of the group homes did not comply with food service requirements; 4 of the group homes did not comply with safety and emergency preparedness requirements; and 1 group home did not comply with physical facility and equipment requirements. In addition, Oklahoma's requirements for monitoring vehicles is inadequate to ensure the safety of all vehicles used to transport children.

We note that certain issues of noncompliance found during our review can frequently occur between State monitoring visits. However, other issues of noncompliance represent a prolonged period of noncompliance and should have been corrected if those issues had been documented and resolved during the State's monitoring. These instances of noncompliance with health and safety requirements indicate that Oklahoma and group homes need to take additional measures to ensure that all issues of noncompliance are documented and resolved in a timely manner and that the group homes clearly understand what is required to safeguard and protect the children in their care.

The State completed background checks on all 229 of the employees at the group homes we reviewed.

What OIG Recommends and Oklahoma Comments

We recommend that Oklahoma (1) ensure that monitoring staff document and resolve all issues of noncompliance of group homes in a timely manner, (2) require group home staff to complete specific training requirements related to health and safety regulations, and (3) revise the State licensing requirements for the monitoring of vehicles used to transport children to ensure that Oklahoma monitors all vehicles annually.

Oklahoma concurred with the first and second recommendations but did not concur with the third recommendation. Oklahoma did not agree that State licensing requirements need to be revised for the monitoring of vehicles.