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

California Needs To Improve Oversight of Community-Based Adult Services Providers' Compliance With Health and Safety and Administrative Requirements

Why OIG Did This Review

We have conducted health and safety reviews of adult day care facilities, adult day service centers, and adult foster care homes in various States. Those reviews identified multiple health and safety issues that put vulnerable adults at risk. We conducted this review to determine whether similar issues existed in California's Community-Based Adult Services Program (the Program). California operates the Program under a Federal waiver to its Medicaid State plan. The Program funds community-based adult services for people aged 65 years and older and individuals with disabilities aged 18 years and older who are eligible for medical assistance and require the level of care provided in a nursing home but choose to live in the community. These services include skilled nursing care, social services, therapies, and personal care.

Our objective was to determine whether California's oversight ensured that providers serving vulnerable adults who received services through the Program complied with Federal waiver and State requirements.

How OIG Did This Review

Of the 240 providers in California as of June 30, 2017, we selected 24 providers for our review, based on their geographic location and their history of health- and safety-related deficiencies. We conducted unannounced site visits at the 24 selected providers.

What OIG Found

California's oversight did not ensure that providers serving vulnerable adults who received services through the Program complied with Federal waiver and State requirements. All 24 providers we reviewed did not comply with 1 or more health and safety or administrative requirements. The 24 providers reviewed each had from 1 to 21 instances of noncompliance. In total, we found 290 instances of noncompliance with health and safety and administrative requirements.

According to State officials from the administering departments, relicensing surveys were not always conducted within the required 2-year timeframe because of competing priorities and staffing issues. In addition, because recertification focuses on quality-of-care issues, some instances of noncompliance related to the centers' physical environment were not always identified during inspections.

What OIG Recommends and California Comments

We recommend that California (1) ensure that the 24 providers we reviewed correct the 290 instances of noncompliance identified in this report and (2) work with the other administering departments to improve the oversight of providers to ensure that relicensing surveys are conducted within the required 2-year timeframe and recertification inspections evaluate all applicable compliance areas.

California agreed with both of our recommendations and stated that it has prepared corrective action plans to implement our recommendations. California also described corrective actions that the administering departments had taken or planned to take to implement our recommendations.