

Report in Brief

Date: May 2018

Report No. A-05-17-00009

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. These reviews identified multiple health and safety issues, and we chose the Elderly Waiver program (the program) to determine whether there may be similar health and safety risks affecting vulnerable adults receiving services in licensed adult day care centers (centers). The program funds home and community-based services, such as services received at a center for people aged 65 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.

Our objective was to determine whether Minnesota 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 104 centers in Minnesota where vulnerable adults received services through the program for the quarter ended June 2016, we selected 20 centers for our review. We selected the centers on the basis of their geographic location and history of health- and safety-related violations identified by the State. We conducted unannounced site visits from February 10 through March 29, 2017.

Minnesota Did Not Comply With Federal Waiver and State Requirements for All 20 Adult Day Care Centers Reviewed

What OIG Found

Minnesota did not comply with Federal waiver and State requirements in overseeing centers that serve vulnerable adults who receive services through the program. To protect the health and safety of vulnerable adults, Minnesota, as the licensing agency for centers, must ensure that centers follow licensing requirements in State statutes established in its application for waiver services. These licensing requirements include health and safety and administrative requirements.

We determined that all 20 of the centers we reviewed did not comply with State licensing requirements. In total, we found 200 instances of noncompliance with health and safety and administrative requirements.

Minnesota said that the instances of noncompliance occurred because low staffing levels did not allow State licensors to make relicensing visits every 2 years. Additionally, Minnesota and the centers indicated that there was a need to develop templates for administrative records that the State requires.

What OIG Recommends and Minnesota Comments

We recommend that Minnesota ensure that the 200 instances of noncompliance with health and safety and administrative requirements identified in this report are corrected, ensure vulnerable adults' health and safety by considering staffing standards and caseload thresholds for State licensors, and consider developing templates for the administrative records the State requires.

Minnesota agreed with our findings and recommendations and described corrective actions that it has taken and will take in response to our recommendations.