Why OIG Did This Audit
Congress has expressed concerns about the safety and well-being of children in foster care. Additionally, in a recent series of audits of State-monitored child care facilities in various States, we found that the majority of child care providers had instances of potentially hazardous conditions and noncompliance with State health and safety requirements, including employee background record check requirements. To determine whether similar vulnerabilities exist in foster care group homes, we performed this audit in Kansas. Allegations of neglect and abuse at some foster care group homes in Kansas were the subject of a number of reports in the media, both before and during our audit.

Our objective was to determine whether Kansas ensured that foster care group homes complied with State licensing requirements related to the health and safety of the residents, and whether the group homes were in compliance with Federal laws and regulations.

How OIG Did This Audit
We conducted site visits at all of the 31 foster care group homes that were licensed to house between 5 and 24 foster care children to determine whether the group homes complied with State licensing requirements related to health and safety. We reviewed background record check completion dates for each group home employee who could engage in unsupervised contact with children in foster care.

Kansas Did Not Ensure That Group Homes for Children in Foster Care Complied With All State Health and Safety Requirements

What OIG Found
Kansas did not ensure that all foster care group homes complied with State licensing requirements related to the health and safety of children in those group homes in accordance with Federal laws and regulations. Specifically, at the times of our site visits we found that 24 of the 31 group homes did not comply with State environmental requirements; this is because Kansas did not address all instances of noncompliance with environmental standards during annual inspections. In addition, 29 of the 31 group homes did not comply or could not document compliance with the required background record check or fingerprint submission requirements for employees. These instances occurred because Kansas did not ensure that the required background checks for all employees were requested in a timely manner. Furthermore, 1 of the 31 group homes did not comply with the terms of its State licensing requirements because it housed both male and female children but was licensed to house only female children. Nevertheless, Kansas allowed this foster care group home to continue operations and did not require that the home submit a request for an amended license allowing the home to also house males.

What OIG Recommends and Kansas Comments
We recommend that Kansas: (1) follow up with all foster care group homes to verify that all of the maintenance deficiencies that we identified are corrected, (2) improve controls to ensure that group homes are in compliance with State licensing requirements related to the health and safety of the residents, and (3) ensure that corrective action is taken when issues of noncompliance are found. We also make procedural recommendations to Kansas regarding the controls over and timely completion of background record checks and the monitoring of the group homes to ensure that they are in compliance with the age and gender requirements of their State licensing agreements.

Kansas concurred with all of our recommendations and with our finding on the foster care group home that housed both male and female children; this group home lost its license and was closed. Kansas also described corrective actions taken or planned. Kansas disagreed with our other findings and provided additional documentation regarding some of them. After reviewing that material, we revised the number of errors we identified. We acknowledge Kansas’s oversight efforts and corrective actions but continue to hold that our findings as revised—and all of our recommendations—are valid.

The full report can be found at [https://oig.hhs.gov/oas/reports/region7/71906087.asp](https://oig.hhs.gov/oas/reports/region7/71906087.asp).