City of New York

OFFICE OF THE COMPTROLLER

Scott M. Stringer
COMPTROLLER

MANAGEMENT AUDIT

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Deputy Comptroller for Audit

Audit Report on the Safety and Wellbeing of Infants Residing in Sampled Department of Homeless Services Shelters

MG19-110A
December 21, 2020
http://comptroller.nyc.gov

THE CITY OF NEW YORK
OFFICE OF THE COMPTROLLER
SCOTT M. STRINGER

December 21, 2020

To the Residents of the City of New York:

My office has audited the New York City Department of Homeless Services (DHS) to determine whether providers of sampled homeless shelters designated for families with children ensure the safety and wellbeing of infants. We audit City entities such as DHS as means of increasing accountability and ensuring that City programs operate in the best interest of the public.

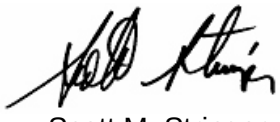
The audit found that the providers of sampled homeless shelters for families with children do not adequately ensure the safety and wellbeing of infants residing at their shelters. Our inspection of 91 randomly selected units with infants at 13 shelters, during the period of December 9, 2019 through March 12, 2020, revealed 264 deficiencies in two broad categories that raised concerns about infants' safety and health: (1) unsafe sleep conditions; and (2) inadequate unit conditions. The unsafe sleep conditions involved crib-related deficiencies and the absence of required safe sleep posters. Inadequate unit conditions included deficiencies such as exposed electrical outlets, mold and mildew, vermin infestation, and accessible hazardous substances. The audit also found that shelter management did not consistently make timely updates of electronic case records to reflect the arrival of newborn infants in families residing in their shelters. Two factors contributed to these deficiencies: (1) shelters did not diligently inform families of safe sleep protocols; and (2) shelters did not consistently perform and/or document the required unit inspections. These performance failures raise particular concerns because there were no apparent consequences for noncompliant shelter operators.

The audit makes 10 recommendations to address these issues, including recommendations to DHS that it: ensure that the shelter providers promptly inspect and correct the conditions that raise safety and health concerns; enforce its written policies and procedures and update them to include a specific time frame in which shelters must enter new information into the electronic case records; and establish and enforce consequences for noncompliance with infant safety policies. The audit also makes recommendations to the shelter providers including that they: play the prescribed safe sleep instructional video for all families with infants; and conduct the required weekly unit inspections, document the results in a timely manner, and take prompt corrective action to address any deficiencies they find.

The results of the audit have been discussed with DHS officials throughout the audit, and their comments have been considered in preparing this report.

If you have any questions concerning this report, please e-mail my Audit Bureau at audit@comptroller.nyc.gov.

Sincerely,



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MG19-110A

EXECUTIVE SUMMARY

The mission of the New York City Department of Homeless Services (DHS) is to prevent homelessness, address street homelessness, provide safe temporary shelter, and connect New Yorkers experiencing homelessness to suitable housing. To accomplish these goals, DHS collaborates with not-for-profit partners to provide temporary shelter and various services that homeless New Yorkers need to transition to permanent housing. These providers connect homeless families and individuals with a range of resources, including case management, housing placement assistance, mental health services, and other critical types of assistance.

According to DHS, approximately 50 infants in New York City die from preventable, sleep-related injuries each year. DHS participates in a Safe Sleep Initiative that the City's Administration for Children's Services (ACS) and Department of Health and Mental Hygiene (DOHMH) initiated in or around 2015. As part of that initiative, in 2018, DHS issued DHS-PB-2018-01, titled "Safe Sleep Policy on Infants in Shelters for Families with Children" (Safe Sleep Policy), a policy intended to provide shelters with guidelines for safe sleep practices for infants. The Safe Sleep Policy includes provisions (such as the use of stationary or portable crib) for the safety and wellbeing of infants whose families reside at a shelter. DHS also requires shelters to show families a safe sleep video within 48 hours of their arrival. Shelter staff are required to have each family sign a Safe Sleep Education Acknowledgment and Crib Acceptance/Refusal Form (safe sleep form). If a family decides to use its own crib, shelter staff must obtain approval from DHS.

DHS also requires shelter staff to conduct weekly unit inspections for families with infants. Shelter staff document such inspections by entering a unit inspection note in the Client Assistance and Rehousing Enterprise System (CARES) maintained by DHS and maintaining hard copies of the completed inspection forms within each client's physical file. DHS monitors shelters by conducting semiannual reviews of all shelters using a checklist drawn from State and local regulations to assess and ensure compliance. At the conclusion of the evaluation, DHS issues a letter to each provider, outlining the issues noted during the evaluation and requiring shelters to take action to remedy the deficiencies the evaluation identified, if any.

During Fiscal Year 2019, DHS managed 2 City-operated and 155 provider-operated shelters that served families with children.[1] According to DHS officials, during Fiscal Year 2019, DHS provided shelter to approximately 25,661 families with approximately 46,454 children including 4,824 infants.

Audit Findings and Conclusions

The providers of sampled homeless shelters for families with children do not adequately ensure the safety and wellbeing of infants residing at their shelters. Our inspection of 91 randomly selected units with infants at 13 shelters, during the period of December 9, 2019 through March 12, 2020, revealed 264 deficiencies in two broad categories—(1) unsafe sleep conditions and (2) inadequate unit conditions—that raised concerns about infants' safety and health. The unsafe sleep conditions we observed involved crib-related deficiencies and the absence of required safe sleep posters. Inadequate unit conditions included defects such as exposed electrical outlets, mold and mildew, vermin infestation, and accessible hazardous substances. We found deficiencies in all 13 shelters we visited and found 4 or more safety concerns in 32 units in 11 of those shelters. In reviewing DHS records, we also found that shelter management often did not update CARES timely to reflect the arrival of newborn infants in families residing in their shelters, which may reduce DHS's ability to effectively monitor infants residing in shelter.

Two factors contributed to both the unsafe conditions for infants we found at these shelters and the shelters' failures to report the presence of newborns in CARES timely: (1) shelters did not diligently inform families of safe sleep protocols; and (2) shelters did not consistently perform or document the required unit inspections. As a result of the above-mentioned unsafe conditions and lack of timely recordkeeping, risks to the safety and wellbeing of infants residing in these shelters were significantly increased. Subsequent to our shelter inspections, which were conducted with shelter staff, we asked DHS what, if any, actions had been taken to correct the conditions we had observed. DHS' response indicates that of the 264 deficiencies we observed, 22 deficiencies pertained to two shelters that had been closed in June 2020, subsequent to our observations. Nearly half of the issues (3 at one shelter and 7 at the other one) remained unresolved prior to the closings. Of the remaining 242 deficiencies, according to DHS, 104 (43 percent) had been addressed prior to our inquiry with DHS; 118 (49 percent) were addressed after we followed up with DHS; 7 (3 percent) were scheduled to be addressed by the end of October 2020; and 13 (5 percent) had not been addressed either by the date of the client's departure from the shelter or as of November 2, 2020, the last date DHS provided us with information. These 13 issues had been outstanding from 15 through 329 days since the time we first observed them.

The above-mentioned performance failures raise particular concerns because there were no apparent consequences for noncompliant shelter operators. Despite poor performance evaluation scores for 5 of the 13 shelters in our sample, all 5 shelters were nevertheless offered opportunities to continue doing business with the City. If the conditions we found at these sampled shelters are consistent with conditions at the remaining shelters contracted by DHS, the City faces an increased risk that providers managing shelters throughout the City are offering inadequate housing to homeless families.

[1] The 155 provider-operated shelters consisted of 306 locations and were operated by 51 providers. Two additional locations were City-operated.

Audit Recommendations

To address the issues raised by this audit, we make 10 recommendations, including that:

- DHS should ensure that the shelter providers promptly inspect and correct the conditions that raise safety and health concerns in the 13 sampled shelters identified in this report.
- DHS should update, and enforce, its written policies and procedures to include a specific timeframe in which shelters must update their records in CARES, any successor system, and other records to account for the presence of all infants. The written policies and procedures should cover, at a minimum, updates to the family composition records, and a standard, readily searchable, contemporaneous record of the date every infant, including every newborn, begins residing in the shelter.
- Shelter staff should ensure that they play the prescribed safe sleep instructional video for all families with infants and then obtain properly completed Safe Sleep Education/Acknowledgment and Crib Acceptance/Refusal Forms on time from all families with infants and that they use only the updated form DHS prescribes.
- Shelter staff should ensure that they perform the required weekly unit inspections, that they document the results in a timely manner, and that they take prompt corrective action to address the deficiencies they find.
- DHS should establish and enforce consequences for noncompliance with infant safety policies.

Agency Response

The audit made ten recommendations to DHS. In its response, DHS generally agreed with nine recommendations, although it contends that it was already in compliance with three of them. DHS disagreed with the remaining recommendation (#9) that it reassess the degree to which its semiannual review adequately addresses issues of infant safety and reconsider the detail in which it reports the deficiencies identified through its reviews in letters to providers. In its response, DHS listed the positive attributes it believes it has incorporated within its semiannual review, effectively rejecting the auditors' recommendations that its current practices need to be improved.

DHS' response also included objections to our methodology. After carefully reviewing DHS' arguments, we found no basis to change any of the report's findings or conclusions. The full text of DHS' response is included as an addendum to this report.

AUDIT REPORT

Background

The mission of DHS is to prevent homelessness, address street homelessness, provide safe temporary shelter, and connect New Yorkers experiencing homelessness to suitable housing. In April 2016, as part of a restructuring process, the Mayor appointed the Commissioner of the City's Human Resources Administration (HRA) to also head DHS, with both agencies operating under the Department of Social Services (DSS).[2]

DHS collaborates with not-for-profit partners to provide temporary shelter and various services that homeless New Yorkers need to transition to permanent housing. These providers connect homeless families and individuals with a range of resources, including case management, housing placement assistance, mental health services, and other critical supports such as employment services, public benefits, and health care.

DHS oversees 157 shelters that provide services to "families with children," defined by DHS to include as: (a) families with children younger than 21 years of age; (b) pregnant women; and (c) families with a pregnant woman. All families with children must apply for shelter at the Prevention Assistance and Temporary Housing (PATH) office. PATH establishes a family's eligibility and conducts interviews to assess the family's medical, educational, and social services needs, as well as disability requirements, dietary, and other special needs. This screening provides staff with factors to consider in selecting a shelter that can best accommodate a family's specific needs, especially as they relate to children and infants.[3]

According to DHS, approximately 50 infants residing in New York City die from preventable, sleep-related injuries each year. DHS participates in a Safe Sleep Initiative that ACS and DOHMH initiated in or around 2015. As part of that initiative, in 2018, DHS issued policy DHS-PB-2018-01, titled "Safe Sleep Policy on Infants in Shelters for Families with Children" (Safe Sleep Policy), to provide shelters with guidelines for safe sleep practices for infants. The Safe Sleep Policy includes the following provisions:

- use of DHS-approved stationary or portable crib;
- use of a firm mattress with a fitted sheet;
- not placing pillows, soft bedding materials, or stuffed animals under the infant's head or anywhere in the infant's crib;
- not placing a crib near safety hazards such as radiators or other heating sources, exposed outlets (outlets that are not child-proofed), or sharp edges;
- keeping the infant's sleep area free of hazards such as dangling cords, electric wires, and window covering cords—all of which present a risk of strangulation.

DHS requires shelters to provide DHS-approved cribs to families with children ages two years or younger immediately upon their entry into the shelter and to show them a safe sleep video within

[2] The objective of this merger was to improve HRA and DHS client services through integrated management. Although HRA and DHS are both part of DSS and therefore share a commissioner as well as certain administrative functions, they have distinct programmatic functions, operations, and staff.
[3] For the purposes of this audit, the term infant refers to children 0-12 months of age.

48 hours of their arrival. Subsequently, shelter staff must have the families complete and sign a Safe Sleep Education Acknowledgment and Crib Acceptance/Refusal Form and place it in the client's file. If a family refuses to watch the video or prefers to use its own crib, shelter staff must document the family's wishes on the form. In cases where a family decides to use its own crib, shelter staff must obtain approval for the alternate crib from DHS.

DHS also requires shelter staff to conduct weekly unit inspections for families with infants to monitor the conditions of the units and to ensure the safety of the infants residing within them. This responsibility includes ensuring that the family is using the crib properly and taking action whenever staff observe unsafe sleep conditions or other conditions deemed potentially harmful to an infant within the environment. Shelter staff must document such inspections in two ways: by entering a unit inspection note in CARES, and by maintaining hard copies of the completed inspection forms within each client's physical file.[4]

CARES is DHS' electronic case management system of record. It is used to capture and preserve information about each client family, including the care and services they receive while staying at a DHS-operated or contracted shelter and any changes in the family's composition, such as when an infant is born to a family residing in a shelter.

DHS monitors shelters to ensure that the providers maintain them in adequate physical condition and that the residents receive necessary services. As part of this monitoring process, DHS requires program analysts from its Transitional Family Services Unit to conduct semiannual reviews of all shelters using a checklist drawn from State and local regulations to assess and ensure compliance. These evaluations cover the physical conditions of the units where the families reside and the safety of the infants residing within the units. Program analysts record their observations and reviews electronically on DHS' Monitoring Instrument form. At the conclusion of the evaluation, DHS issues a letter to each provider, along with the results of the monitoring instrument, outlining the issues noted during the evaluation and requiring shelters to take action to remedy the deficiencies the evaluation identified, if any.

During Fiscal Year 2019, DHS managed 2 City-operated and 155 provider-operated shelters that served families with children. According to DHS officials, during Fiscal Year 2019, DHS provided shelter to approximately 25,661 families with approximately 46,454 children including 4,824 infants.

Objective

The objective of this audit was to determine whether providers of sampled homeless shelters designated for families with children ensure the safety and wellbeing of infants.

Scope and Methodology Statement

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objective. We believe that the evidence obtained provides a reasonable basis for our findings

[4] Prior to January 27, 2020, shelters were allowed to document inspections on shelter-defined forms. After January 27, 2020, the inspection form was standardized by DHS.

and conclusions based on our audit objective. This audit was conducted in accordance with the audit responsibilities of the City Comptroller as set forth in Chapter 5, §93, of the New York City Charter.

The scope of this audit was July 2018 through March 2020. Please refer to the Detailed Scope and Methodology at the end of this report for the specific procedures and tests that were conducted.

Discussion of Audit Results with DHS

The matters covered in this report were discussed with DHS officials during and at the conclusion of this audit. A preliminary draft report was sent to DHS and discussed at an exit conference held on October 22, 2020. On November 20, 2020 we submitted a draft report to DHS with a request for comments. We received a written response from DHS on December 7, 2020.

The audit made ten recommendations to DHS. In its response, DHS generally agreed with nine recommendations, although it contends that it was already in compliance with three of them. DHS disagreed with the remaining recommendation (#9) that it reassess the degree to which its semiannual review adequately addresses issues of infant safety and reconsider the detail in which it reports the deficiencies identified through its reviews in letters to providers. In its response, DHS listed the positive attributes it believes the agency has incorporated within its semiannual review, effectively rejecting the auditors' recommendations that its current practices need to be improved.

DHS' response also included objections to our methodology. DHS stated,

> As an initial matter, we have always valued the collaborative work with the Comptroller's Office to improve our performance and client services. In this particular audit process, however, we are concerned that the determination to exclude DHS staff from the site visits and then the substantial delay in providing DHS staff with the site visit observations impeded the agency's ability to take immediate action to remedy deficiencies. We urge you to rethink this approach. Fortunately, while the audit was pending and before DHS received information from the auditors, DHS staff took independent action to address many of the issues in the normal course.

DHS purports to identify an irregularity where there is none. To ensure that we gain a true representation of the conditions at a shelter, it is our practice to inspect a shelter unannounced, which necessitates that we go unaccompanied by DHS. (This is exactly the practice that we have followed in numerous previous DHS audits.) During such visits, we also interview shelter staff and other persons present to determine their knowledge of the policies of the audited program and whether their roles are consistent with such policies. To create an environment that encourages participants to speak freely, we may conduct such interviews without agency personnel (in this case, DHS) present. In fact, we noted that during initial interviews with shelter management during this audit at which DHS officials were present, the DHS officials created an environment that may have inhibited the interviewees from fully sharing information with the audit team. For example, in the middle of one interview at a shelter we visited early in our interview and inspection process, DHS staff asked the audit team to leave the room while DHS staff had a conversation with shelter management, after which we resumed the interview with shelter staff and DHS staff still present.

In addition, during the course of our initial meetings, we learned that DHS had instructed shelter management to refrain from providing documentation to the audit team before it was reviewed by DHS management, potentially compromising the degree of reliance we could place on the information that we later received.

DHS also disingenuously attributes its failure to immediately take action to resolve deficient shelter conditions to the length of time between our visits and our follow-up with DHS. However, at the beginning of our audit, we informed DHS that we would be performing unannounced visits, giving the agency an opportunity, if it so wished, to reach out to all shelters housing families with children to let them know that they might be among those we visited. Additionally, shelter staff accompanied the audit team during each visit and were aware of all the conditions we cited. Pursuant to DHS policy, shelters are responsible for informing DHS of all deficient conditions at their facilities, recording them in CARES, and correcting them as soon as possible. Accordingly, it was our expectation that DHS—as part of its regular monitoring of *all* shelters that provide service to families with children—would follow up with those shelters we had visited regarding the correction of any deficiencies we might have identified. Hence, when we later contacted DHS, our primary intent was not to "provide" the agency with the results of our observations but rather to determine whether the cited deficiencies had been corrected. DHS' argument that it was seemingly unaware of the conditions until we followed up with DHS officials underscores what appears to be a significant factor that contributed to the deficiencies identified in this audit, namely, that DHS does not exercise adequate oversight to ensure that shelters inspect units on a regular basis and promptly correct deficiencies.

For example, DHS cites a heating condition identified by the auditors in an inspection as "an example of why it would be so important for DHS staff to accompany auditors on inspections, as this would have allowed DHS to hold the provider immediately accountable to ensure that [the] condition was remediated promptly, instead of learning about the heat condition the following August, several months after it was noticed by the auditors and well after heat season had ended." However, the CARES records reflect that an entry was made on December 9, 2019—the day of our visit—documenting the inspection we performed, along with a detailed listing of the deficiencies observed, including the heating condition. Had the DHS program analysts who are responsible for monitoring the shelters regularly reviewed CARES, as required by DHS' policy, DHS would have been aware of the issue and had an opportunity to resolve the heating issue well before the heating season ended.

In fact, our review of CARES revealed that some of the deficiencies we observed during our inspections were noted in CARES *prior to our visits*. For example, we found that a family at one shelter was using a crib that had not been approved by DHS. Our subsequent review of CARES revealed that this issue had been documented a month prior to our visit and 14 more times thereafter before the issue was resolved—four months after our visit—bringing into question the degree of DHS' oversight. Nevertheless, we commend DHS for recognizing its deficiency in this area. As DHS states in its response to recommendation #1, as of November 2020—subsequent to the issuance of the preliminary report of this audit—DHS has implemented a new formal requirement that case managers must randomly review shelter case notes no less than on a weekly basis.

In its response, DHS is also critical of the fact that the audit report fails to recognize that some shelters "are being phased out as part of a publicly reported effort to transform the shelter system by raising the bar." As stated in the report, although 5 of the 13 shelters we visited received overall scores of "poor" on their reviews for the second half of Fiscal Year 2019, DHS nevertheless

allowed four of those five shelters to continue operating and to do business with the City. DHS only closed one of the multiple locations of the fifth shelter, which, according to DHS, was closed as part of its efforts to reduce the use of non-contracted shelters and commercial hotels, rather than as consequence of poor performance or DHS' efforts to "raise the bar."

After carefully reviewing DHS' arguments, we found no basis to change any of the report's findings or conclusions. The full text of DHS' response is included as an addendum to this report.

FINDINGS AND RECOMMENDATIONS

The providers of sampled homeless shelters for families with children do not adequately ensure the safety and wellbeing of infants residing at their shelters. Our inspection of 91 randomly selected units with infants at 13 shelters, during the period of December 9, 2019 through March 12, 2020, revealed 264 deficiencies in two broad categories—(1) unsafe sleep conditions and (2) inadequate unit conditions—that raised concerns about infants' safety and health. The unsafe sleep conditions we observed involved the nonuse, improper use, placement, and condition of cribs, and the absence of required safe sleep posters. Inadequate unit conditions included defects such as exposed electrical outlets and sharp edges, mold and mildew, vermin infestation, missing and broken window guards, accessible hazardous substances, and dirty and cluttered units, among others.

During our visits, we found at least one deficiency in 92 percent of the units we inspected. Further, we found deficiencies related to health and safety concerns in all 13 shelters we visited and found 4 or more safety concerns in 32 units in 11 of those shelters. In addition, in reviewing DHS records we found that shelter management often did not update CARES timely to reflect the arrival of newborn infants in families residing in the shelters.

As a result of the above-mentioned unsafe conditions and lack of timely recordkeeping, risks to the safety and wellbeing of infants residing in these shelters were significantly increased. When we asked DHS what, if any, actions had been taken by the shelters to correct the conditions we observed, DHS officials informed us that two of the sampled locations were closed in June 2020, which accounts for 22 of 264 issues cited in our report. At the time they were closed, 10 issues (3 at one shelter and 7 at the other one) remained unresolved prior to closing. In addition, DHS' response also indicated that, of the remaining 242 deficiencies we observed, 104 (43 percent) had been addressed prior to our inquiries to DHS about them and 118 (49 percent) were addressed after our inquiry. In addition, DHS indicated that 7 (3 percent) were scheduled to be addressed by the end of October 2020. Finally, 13 (5 percent) of the deficiencies we observed had not yet been addressed either by the date of the client's departure from shelter or as of November 2, 2020, the last date that DHS provided us with information about corrective actions having been taken. These 13 issues had been outstanding from 15 through 329 days since the time we first observed them.

Two factors contributed to both the unsafe conditions for infants we found at these shelters and the shelters' failures to report the presence of newborns in CARES timely: (1) shelters did not diligently inform families of safe sleep protocols; and (2) shelters did not consistently perform or document the required unit inspections. These performance failures raise particular concerns because there were no apparent consequences for noncompliant shelter operators. Notwithstanding poor performance evaluation scores for 5 of the 13 shelters in our sample, all 5 shelters were nevertheless offered opportunities to continue doing business with the City. If the conditions we found at these sampled shelters are consistent with conditions at the remaining shelters contracted by DHS, the City faces an increased risk that providers managing shelters throughout the City are offering inadequate housing to homeless families.

The following sections of this report present these findings in detail.

Infant Safety and Health Conditions at Sampled Shelters Are Inadequate

Infant safety and health conditions at the homeless shelters we visited were not adequate based on DHS' standards. Our inspections identified 264 conditions related to 84 (92 percent) of the 91 units we inspected that raise safety and health concerns for the infants residing in those shelters.

According to DHS' Safe Sleep Policy:

- Immediately upon a family's or infant's arrival at the shelter, shelter staff must provide one DHS-approved crib per child aged two years and younger. Shelter staff must also post a Safe Sleep Flyer in a visible location near the crib.
- If a family prefers to use its own crib, shelter staff must confirm that the crib is in good working condition, notify their respective DHS program administrators, and obtain DHS' approval on the appropriateness of the family's selected crib.
- Regardless of whether the family uses its own crib or one provided by DHS, shelters must ensure that families: (1) maintain their cribs in clutter free condition, so that the cribs can be used for their intended purpose, and (2) place the cribs in safe locations—away from hazards.
- Shelters require residents to maintain their units in a satisfactory manner, consistent with standards established through laws, rules, and DHS procedures, and must address and correct inappropriate conditions.

To determine the degree to which the City's family shelters maintain safe and clean unit conditions in accordance with DHS policies, we randomly selected 91 units with infants at the 13 shelters we visited. Using the conditions assessed by DHS during its semiannual reviews, we developed our own checklists. We visited the 13 provider-operated shelters, accompanied by shelter staff, between December 9, 2019 and March 12, 2020 to assess the conditions within the units.

The 264 deficiencies that our inspections identified raised concerns about safety and health conditions related to two categories delineated below.

(1) Unsafe Sleep Conditions–units with one or more of the following deficiencies:

- Not using a DHS-approved crib
- Cluttered cribs, which includes using the crib for other than its intended purpose
- Cribs placed near hazardous location(s)
- Units with missing Safe Sleep Flyer

(2) Inadequate Unit Conditions–units with any of the following deficiencies:

- Exposed outlets/sharp edges
- Mold and mildew
- Signs of vermin
- Units needing repairs

- Missing/broken window guards or locks
- Defective fire alarm/carbon monoxide detector
- Obstructed emergency exit
- Accessible hazardous substances
- Dirt and clutter

Table I below shows the distribution of defects found in our sample of 13 shelters by the number of units with concerns within each shelter.

Table I
Shelter Units with Safety and Health Concerns
Due to Unsafe Sleep and Inadequate Unit Conditions

Shelter	Total # of Units Inspected	# of Units with No Deficiencies	# of Units with Deficiencies	# of Units with One Safety Deficiency	# of Units with Two Safety Deficiencies	# of Units with Three Safety Deficiencies	# of Units with Four or More Safety Deficiencies
HELP – Bronx Crotona	10	0 (0%)	10 (100%)	1	3	4	2
University Family Center	10	0 (0%)	10 (100%)	0	2	5	3
Bronx Neighborhood Aguila	10	0 (0%)	10 (100%)	0	5	4	1
Urban Strategies	8	0 (0%)	8 (100%)	2	1	4	1
Flagstone Family Services	9	1 (11%)	8 (89%)	1	2	0	5
Jennie A Clarke	8	0 (0%)	8 (100%)	0	1	1	6
Staten Island Family Center	1	0 (0%)	1 (100%)	0	0	1	0
Bronx Bridge 1	4	0 (0%)	4 (100%)	0	1	0	3
Community Outreach	2	0 (0%)	2 (100%)	0	0	1	1
New Dawn Hotel	4	2 (50%)	2 (50%)	1	1	0	0
Manhattan Hotels	12	4 (33%)	8 (67%)	3	1	1	3
Belt Family Center	3	0 (0%)	3 (100%)	0	1	1	1
Metro Family Residence	10	0 (0%)	10 (100%)	2	2	0	6
Total	91	7 (8%)	84 (92%)	10	20	22	32

As indicated above, our visits revealed one or more safety- and health-related deficiency in 92 percent of the units we inspected. Further, we found deficiencies in all 13 shelters we visited, and 32 of the units with noted conditions (38 percent)—in 11 shelters—had 4 or more safety concerns.

In one shelter, which conducted on average only 53 percent of the required weekly unit inspections, we observed a unit with a large hole in a bedroom door, a glue trap placed on the kitchen floor, food remnants and garbage strewn throughout the apartment, sticky floors, a foul rotting odor, and a strong smell of cigarette smoke. In a second shelter, which conducted on average 45 percent of the required inspections, we observed live roaches and other insects on a kitchen wall and a crib filled high with clothes and toys. In the same unit, we observed a crib with

rodent droppings on the mattress. Although shelter staff claimed the family residing in the unit did not use this crib for an infant to sleep in, evidence that vermin were able to access the crib at the mattress's height was of particular concern. Additionally, the claim that no infant had been sleeping in the rodent-soiled crib raised the question of where the infant (one of two infants residing in the unit) *was* sleeping and if that location was safe. And in a third shelter, which conducted on average only 25 percent of the required inspections per unit, we found a unit where the crib mattress was damaged, there was no heat (in December), the heater was infested with live roaches, and the family resorted to taping plastic around the window to keep the cold air out.

As noted, shelter staff accompanied us on our observations and, therefore, became aware of the conditions we observed at the same time we did. We later contacted DHS management to learn whether the sampled shelters had taken corrective measures after our visits. DHS informed us that two of the sampled locations had been closed in June 2020. Together, they had 22 of 264 issues cited in our report. At the time they were closed, 10 unresolved issues remained, 3 at one shelter and 7 at the other one. Our analysis of DHS' responses for the remaining 242 deficiencies shows that the shelters had addressed fewer than half the issues before we made our inquiries. Of the 242 deficiencies we observed, 104 (43 percent) were addressed prior to our inquiry; 118 (49 percent) were addressed after our inquiry; and 7 (3 percent) were scheduled to be addressed by the end of October 2020. That left 13 deficiencies (5 percent) that had not yet been addressed either by the date of the client's departure from shelter or as of November 2, 2020, the last date that DHS provided information. These 13 issues had been outstanding from at least 15 through 329 days based on the dates we first observed them. Due to restrictions put in place during the COVID-19 pandemic, we were unable to re-inspect the conditions at the shelters or to verify that the issues had been adequately resolved as reported.

Unsafe Sleep Conditions

Table II below shows the total numbers of deficiencies and affected units related to the safety of infants' sleeping conditions observed during our inspections.

Table II

Number of Units with Unsafe Sleep Conditions

Shelter	# of Units Inspected	# of Units with Safe Sleep Issues	% of Units with Safe Sleep Issues	Issues Observed with Unsafe Sleep Conditions				Total # of Unsafe Sleep Conditions Per Shelter
				Units Not Using a DHS-Approved Crib	# of Units with Cluttered Crib	# of Units with Crib Placed Near Hazardous Location	# of Units with No Safe Sleep Flyer	
HELP – Bronx Crotona	10	6	60%	1	3	2	3	9
University Family Center	10	10	100%	0	7	2	9	18
Bronx Neighborhood Aguila	10	5	50%	1	2	1	2	6
Urban Strategies	8	3	38%	0	1	2	2	5
Flagstone Family Services	9	6	67%	0	4	2	5	11
Jennie A Clarke	8	4	50%	1	2	1	0	4
Staten Island Family Center	1	1	100%	0	1	0	0	1
Bronx Bridge 1	4	3	75%	0	3	2	1	6
Community Outreach	2	1	50%	0	0	0	1	1
New Dawn Hotel	4	0	0%	0	0	0	0	0
Manhattan Hotels	12	6	50%	0	5	1	4	10
Belt Family Center	3	2	67%	0	0	2	0	2
Metro Family Residence	10	8	80%	0	2	2	6	10
Total	91	55	60%	3	30	17	33	83

As indicated above, we identified 1 or more unsafe sleep conditions in 55 of the 91 units we inspected (60 percent) and in 12 of the 13 shelters we visited, a total of 83 unsafe sleep conditions overall. These deficiencies detailed below increased the risk to the health and safety of the infants residing in the units we observed.

- Units with Cluttered Cribs: We observed evidence of cluttered cribs (defined by DHS as cribs with anything other than a fitted sheet placed inside) in 30 (55 percent) of the units with safe sleep issues, indicating that the cribs may not have provided optimum safety for sleeping infants. In fact, 10 of the cribs were in such disarray that it was clear that they were used for storage and that the infants were sleeping elsewhere.
- Units with Cribs Placed Near Hazardous Locations: Cribs were placed near hazardous areas, such as near heat radiators and exposed power outlets, in 17 (31 percent) of the units with safe sleep issues, further jeopardizing the infants' safety.[5]
- Units Not Using a DHS-Approved Crib: While for the most part families were using the DHS-approved cribs, shelter staff confirmed that three families were not. We did not find

[5] Seven of the units had a crib that was both cluttered and placed near a hazardous location.

DHS-provided cribs in these units and saw no evidence in the case files to indicate that DHS approved the alternate cribs.

- Units with No Safe Sleep Flyer: The Safe Sleep Flyer instructs the family on infant sleep safety practices such as maintaining a clutter-free crib, ensuring proper sleep positions, and not smoking in the area of the crib. It is intended to help the family better understand how to maintain a safe sleep environment. However, in 33 (60 percent) of the units with safe sleep issues, the Safe Sleep Flyer was not posted anywhere in the unit.

With respect to the unsafe sleep conditions we observed, DHS informed us that 7 of the 83 conditions pertained to the two locations that were closed in June 2020, of which two conditions, one at each shelter, were not resolved prior to closing. Our analysis of DHS responses for the remaining 76 unsafe sleep conditions shows that 47 (62 percent) of the conditions had been addressed prior to our inquiry; 22 (29 percent) were addressed *after* our inquiry; and 7 (9 percent) had not yet been addressed either by the date of the client's departure from the shelter or as of November 2, 2020, the last date that DHS provided information. Those seven conditions had been outstanding for 89 through 329 days since the time we first observed them.

Photo 1 - Cluttered Crib

Photo 2 - Crib Placed Near Exposed Outlet

Photo 3 - Usage of Bassinette Not Approved by DHS

Photo 4 - Mouse Droppings in a Crib

Inadequate and Unsafe Unit Conditions

Table III below depicts the total number of deficiencies pertaining to units with inadequate and unsafe unit conditions observed during our inspections.

Table III

Number of Units with Inadequate and Unsafe Conditions

Shelter	# of Units Inspected	# of Units with Safety Concerns	% of Units with Safety Concerns	# of Units with Inadequate and Unsafe Conditions										Total # of Conditions
				# of Units with Exposed Outlets	# of Units with Sharp Edges	# of Units with Mold/ Mildew in the Bathroom	# of Units with Signs of Vermin	# of Units Needing Repairs	# of Units Missing Window Guards or Locks	# of Units with Defective Fire Alarm and/or Carbon Monoxide Detectors	# of Units with Obstructed Emergency Exits	# of Units with Accessible Hazardous Substances	# of Units that were Dirty and Cluttered	
HELP – Bronx Crotona	10	9	90%	9	0	0	2	1	0	0	0	3	4	19
University Family Center	10	10	100%	10	0	1	0	2	0	0	0	1	0	14
Bronx Neighborhood Aguila	10	10	100%	9	3	0	3	0	0	2	0	2	1	20
Urban Strategies	8	8	100%	8	0	0	0	1	1	0	2	3	0	15
Flagstone Family Services	9	8	89%	8	0	1	4	0	0	1	0	2	1	17
Jennie A Clarke	8	8	100%	8	0	2	3	7	3	0	2	4	2	31
Staten Island Family Center	1	1	100%	0	1	0	0	1	0	0	0	0	0	2
Bronx Bridge 1	4	4	100%	4	4	1	0	1	0	0	0	2	1	13
Community Outreach	2	2	100%	2	0	0	2	0	0	0	0	2	0	6
New Dawn Hotel	4	2	50%	2	0	0	0	1	0	0	0	0	0	3
Manhattan Hotels	12	6	50%	4	3	1	0	2	0	0	0	1	2	13
Belt Family Center	3	3	100%	3	1	1	0	0	0	0	0	2	0	7
Metro Family Residence	10	10	100%	8	0	2	4	2	0	0	0	0	5	21
Total	91	81	89 %	75	12	9	18	18	4	3	4	22	16	181

As reflected above, we found one or more deficiencies pertaining to inadequate and unsafe living conditions in 81 of the 91 units we inspected (89 percent) throughout all 13 shelters we visited. If not resolved, these deficiencies, detailed below, may expose infants to adverse health conditions.

- Units with Exposed Outlets: We observed exposed power outlets reachable to crawling or walking infants in 75 (93 percent) of the units with inadequate and unsafe conditions.
- Units with Sharp Edges: We observed sharp edges (bed frames and radiator covers) reachable to crawling or walking infants in 12 (15 percent) of the units with inadequate and unsafe conditions.
- Units with Mold and Mildew: We observed mold and mildew in the bathrooms of nine (11 percent) of the units with inadequate and unsafe conditions. Prolonged exposure to mold may cause or aggravate various health problems, including asthma, allergies, and other breathing issues.
- Units with Signs of Vermin: We observed evidence of vermin, including live roaches and/or mouse droppings, in 18 (22 percent) of the units with inadequate and unsafe conditions. In one shelter, we observed mouse droppings in the bathroom vanity cabinets of two units. In another shelter, we saw roaches crawl out of kitchen cabinets as we were inspecting the cabinets for hazardous substances. Both examples indicate prolonged infestation, which, over time, can cause or trigger allergies and asthma and, overall, can be detrimental to an infant's health.
- Units Needing Repairs: In 18 (22 percent) of the units with inadequate and unsafe conditions, we found that the units were in need of repairs for such issues as broken heaters, clogged sinks, and loose windows. In their current state, these units pose potential safety and health risks. For example, lack of heat in the unit may lead to hypothermia, and a clogged sink may lead to a build-up of bacteria or an inability to properly clean infant accessories, which ultimately may create a health risk.
- Units with Broken Window Locks and Missing Guards: Four (five percent) of the units with inadequate and unsafe conditions were missing preventive measures against children falling out of windows, as either the window guard was missing or the window lock was broken.[6]
- Units with Broken Fire Alarms and Carbon Monoxide Detectors: In three (four percent) of the units with inadequate and unsafe conditions, both the fire alarms and carbon monoxide detectors were broken.
- Units with Obstructed Emergency Exits: Four (five percent) of the units with inadequate and unsafe conditions had the emergency exits, such as windows with fire escape, obstructed by furniture or boxes.
- Units with Accessible Hazardous Substances: In 22 (27 percent) of the units with inadequate and unsafe conditions, we found that hazardous substances were placed within reach of a crawling or walking infant, including bleach, laundry detergent, and a variety of other cleaning products, which, if accidentally ingested by an infant, can prove to be poisonous and can even be fatal.
- Units that were Dirty and Cluttered: In 16 (20 percent) of the units with inadequate and unsafe conditions, we found that the overall surroundings in the unit were unkempt and, in general, not well maintained. Examples include soiled infant diapers on the floor, trash

[6] Window guards and locks are required by State regulations for shelters for families with children, 18 NYCRR 900.18(h)(8), and by provisions of the City Housing Maintenance Code and the City Health Code applicable to multiple dwellings—buildings with three or more residential units—where a child ten years of age or under resides.

piled up in the room, dirty laundry scattered on the floor, large accumulations of dirty dishes in the kitchen sink and on countertops, and leftover food scattered on the table, bed, and floor throughout the unit. These types of conditions expose crawling or walking infants to unsanitary and unhealthy conditions.

Subsequent to our inspections, DHS informed us that 15 of the 181 inadequate and unsafe unit conditions we observed pertained to the two locations that had been closed in June 2020. Eight of those conditions (two at one shelter and six at the other one) were not resolved prior to the shelters closing. Our analysis of DHS responses for the remaining 166 conditions shows the following: 57 (34 percent) of the conditions were addressed prior to our inquiry; 96 (58 percent) were addressed *after* our inquiry; and 7 (4 percent) were scheduled to be addressed by the end of October 2020. In addition, 6 (4 percent) had not yet been addressed at all either by the date of the client's departure from the shelter or as of November 2, 2020, the last date of submission by DHS -- these issues were outstanding for between 15 and 285 days.

DHS Response: DHS disagreed with the audit's finding that some windows were not adequately insulated, stating that "current local laws do not require an existing building with single pane windows to change to double pane windows if no work is planned; older buildings that have single pane windows do not receive violations for not having double pane windows."

Auditor's Comment: The audit report does not refer to changing single pane windows to double pane. However, windows should be in working condition and should protect the room from draft and cold air. The condition of the windows that we observed did not provide adequate protection from cold air. During our inspections, we observed windows that were drafty and loose and some insulated with plastic bags and cloths.

DHS Response: DHS disagreed that eight of the units in one shelter did not have childproof outlets, stating that "this shelter uses tamper resistant outlets. DHS obtained the purchase receipts for tamper resistant outlets from the provider showing the purchase was made months before the audit. DHS shared these with the auditors, but they were not accepted as proof of installation. These tamper resistant outlets look like regular outlets unless they are closely inspected, which DHS has done to confirm their presence in the units which were inspected by the auditors."

Auditor Comment: We carefully examined all documents and explanations DHS provided as evidence that the condition was corrected or that it never existed and we found DHS' explanations to be insufficient for the following reasons:

- The shelter supervising case manager who accompanied us during the inspection did not provide any evidence that the outlets were tamper resistant (childproof) when we pointed out our concern with the outlets;
- DHS provided us with a photo of an outlet, claiming it was a childproof outlet and had been installed during our visit. However, the outlet in DHS' photo is not the same outlet that we cited;
- DHS provided us with an invoice, dated prior to our visit, for 10 tamper proof outlets. However, based on the serial numbers found on the invoice, we were able to determine that none of the outlets on the invoice were the outlet in the DHS

photo or the outlets that were present during our inspections. Additionally, DHS provided no evidence to indicate that any outlet covers were installed. On November 10, 2020, prior to the issuance of the draft report, we shared the above concerns with DHS and the agency did not provide additional evidence or information to refute them. In the absence of such evidence, we have no basis to alter our finding.

Photo 5 – Sharp Edges

Photo 6 - Mold and Mildew on Ceiling

Photo 7 - Kitchen Cabinet Filled with Mouse Droppings

Photo 8 - Roaches Crawling on Kitchen Wall

Photo 9 - Roaches Crawling Out of Kitchen Cabinet

Photo 10 - Hole in Bedroom Door

Recommendations

1. DHS should ensure that shelter providers consistently and in a timely manner perform all of the required inspections of each unit.

   DHS Response: DHS agreed with this recommendation stating that "it is important to ensure that shelter providers consistently and in a timely manner perform all required unit inspections. We currently monitor for timely unit inspections and include consistency in that monitoring. It is with this in mind that we standardized the unit inspection form for our providers in January of 2020. We also currently require corrective action plans when we identify this as a deficiency during our bi-annual monitoring.

   In addition to our twice annual monitoring activities, DHS has now added weekly random case note reviews to ensure that unit inspections are occurring and are being documented, using the standardized tool introduced in January 2020. This is now occurring for all of our shelter [*sic*]."

   Auditor Comment: The scope of this audit did not include an assessment of DHS' monitoring efforts, so we are unable to comment on the adequacy of those efforts as they pertain to ensuring that shelters conduct unit inspections as required. Nonetheless, we note that the mere creation of a form is not an indication that the form is being properly utilized. In fact, we found that staff in the shelters we visited did not consistently complete the form, nor did they consistently enter details of the inspections into CARES or consistently perform the required number of inspections. With regard to the corrective action plans required from shelters, as noted later in this report, we found that they lacked specifics regarding certain deficiencies found during those reviews, thereby weakening the effectiveness of those reviews.

   Consistent oversight is required to ensure that shelters utilize all tools and resources provided by DHS. Consequently, we commend DHS for agreeing to implement this recommendation and to now incorporate weekly case note reviews.

2. DHS should ensure that the shelter providers promptly inspect and correct the unresolved conditions that raise safety and health concerns in the sampled shelters identified in this report.

   DHS Response: DHS agreed with this recommendation, stating, "DHS agrees with most of the conditions noted in the audit report and we have required our providers to inspect and correct all conditions. We have also strengthened our monitoring for inspections." However, DHS disagreed "with the implication in the report that unresolved conditions were not timely addressed" (discussed in prior sections of the report).

Sampled Shelters Do Not Report the Presence of Newborn Infants to DHS in a Timely Manner

According to the DHS Program Analyst Manual, shelters are responsible for reporting to DHS changes in family composition, such as when infants are born to families residing in homeless shelters. One of the tests DHS performs during its semiannual reviews is to determine whether shelters report the infants born to families residing in the shelter to DHS within seven days of their arrival at the shelter. That written deadline applied to shelter staff until July 29, 2019.[7] Thereafter, according to DHS' Deputy Commissioner of Family Services, the process for updating a family's composition must be completed upon an infant's arrival at the shelter, although that requirement is not spelled out in DHS' written procedures. Accordingly, in our review, we applied the seven-day documented criteria that DHS uses in its semiannual reviews.

We found that the shelters frequently did not update DHS' prescribed family composition records in CARES timely—in some cases for months. Delays of that magnitude, and *any* significant delays, render DHS' vital records incomplete and inaccurate and compromise its ability to monitor and enforce the specific safeguards it has established for sheltered families with infants. Those safeguards include safe sleep protocols and weekly inspections of the units where infants reside. Thus, these delays increase the safety risk for sheltered families with infants.

Our review of CARES records for 104 infants at the 20 sampled shelters revealed that at least 61 (59 percent) of the infants were added to the family composition record on time (within seven days of their arrival at the shelters).[8] However, we also established that at least 20 (19 percent) of the infants were added to the CARES family composition late, that is, more than 7 days after their entry to the shelter.

In addition, the CARES records for the 23 remaining infants lacked sufficient information to show whether the infant either *arrived* at the shelter or was *present* at the shelter for more than 7 days before the staff updated the family composition record. Consequently, we could not conclusively determine whether, or by how many days, those updates were late under DHS' seven-day timeframe. However, those 23 infants were missing from the CARES family composition records for periods of 8 days to 54 days after their birth dates. Those gaps in the CARES records raise various questions, including whether the updates were late, where the infants were residing, and when shelter and DHS staff became aware of their existence as members of the families residing in City shelters.

[7] Up until July 29, 2019, shelter staff were required to notify DHS of the change in a family's composition by submitting a Newborn Indicator form to DHS' Housing Emergency Referral Operations (HERO) unit within seven days of a newborn's arrival at the shelter and to maintain a physical copy of the form within the shelter's "critical files." ("Critical files" should contain current documents related to the security of the shelter and the families residing in it, as described in more detail later in this report.) While that form was in use, HERO staff were charged with adding the newborn to the family's CARES record, and shelter staff were responsible for following up within CARES and communicating with HERO staff in cases of delays or omissions. As of July 29, 2019, the process was changed. Shelter staff are currently supposed to enter required information about each newborn directly into CARES via the Newborn Client Request screen, and HERO staff are charged with reviewing the request and serving as the final approvers of the entry.

[8] CARES showed the dates that 28 of the 61 infants arrived at the shelters, which enabled us to determine that their CARES profiles were created timely. CARES did not show the dates the remaining 33 infants in this category arrived at the shelters, but because these infants' dates of birth were entered into CARES, we were able to verify that the 33 infants were added to the family composition timely, within seven days of their birth dates.

Breakdown of 20 Instances of Infants Added Late to Family Composition Records

The 20 cases where shelters were demonstrably late in adding newborn infants to the family composition records in CARES consist of two groups:

- 9 infants who arrived at the shelter more than 7 days before staff added them to the family composition records—these infants were added between 6 and 39 days late; and
- 11 infants whose shelter-arrival dates were missing from CARES but whose presence in the shelters was documented in other CARES records. Those records show that these 11 infants were residing in the shelters for periods of *not less than* 11 to *not less than* 85 days before the shelters added them to the required family composition records. One infant in this group was born 92 days before the shelter updated the required record.

Breakdown of 23 Instances of Infants Added to Family Composition Records from 8 to 54 Days after Birth Dates

CARES was missing the dates that 23 infants in this group, and 11 others discussed above, arrived at the shelters. However, we determined that these 23 infants were born between 8 and 54 days before the shelters added them to the family composition records. We also reviewed their families' CARES records in detail, including independent living plans and family case notes, to determine whether shelter staff noted the infants' presence in any manner before adding them to the required family composition records. That review revealed the following:

- 12 infants were born between 8 and 26 days before staff added them to the required family composition records. Other notes in CARES reflect their presence 4 days or less before those updates. The gaps of up to 26 days between their birth dates and their addition to the family composition records raise questions of whether the updates were late, where these infants were residing, and how long they resided in the shelters before the staff documented their presence in CARES.
- 11 infants were born between 9 and 54 days before staff added them to the family composition records. CARES contained *no* prior notes of their presence in the shelters. The complete absence of a CARES record for up to 54 days after these infants' birth dates raises questions of whether the updates were late, where these infants were residing, and how long they resided in the shelters before the staff documented their presence in CARES.

Infants Missing from Family Case Files and Rosters

Of particular concern is our finding that in addition to not adding infants to the family composition on time, staff at the shelters did not note the infant's existence anywhere in the family case files for an extended period after the birth. For example, one infant was not mentioned in the unit inspection notes until 22 days after birth. Because shelter staff are supposed to inspect all units weekly, their failure to note the new infant's presence for three weeks raises the question of whether they inspected the unit, and if they did, why they did not note the new infant's presence. This infant was not added to the prescribed family composition record until 64 days after the inspection in question, when the family was transferred to a different shelter.

In addition, during our audit, we found specific instances where staff at the sampled shelters were not aware of an infant's presence at the shelter until the time of our visits. In one such instance, on January 24, 2020, when we visited the Community Outreach shelter, the roster generated from

CARES indicated that only one family with an infant resided there. When we asked the shelter case manager whether additional infants were residing at the shelter, he answered that there was only one family with an infant currently in residence. It was not until nearly three weeks after our visit and numerous requests for Newborn Indicator forms that a different shelter official, the program director, created a log of all infants who had resided in the shelter during 2019 through the date of our January 2020 visit. The log listed one additional infant who had arrived at the shelter six days prior to our visit but who had not been noted in CARES at the time of our visit—an infant whose presence the case manager was apparently unaware of.

This additional infant was not added to CARES until February 11, 2020—nearly a month after the infant entered the shelter. Under DHS requirements, shelter staff should have added the infant to the family composition no later than 7 days of the infant's arrival at the shelter. Had they done so, the CARES roster should have reflected the infant's presence long before it did. At the very least, the case manager should have been aware of the infant's presence before we visited the shelter to ensure that the shelter implemented the safe sleep protocols and other safeguards applicable to infants.

The above example was not an isolated incident. In late March 2020, we obtained CARES rosters for the 13 shelters we visited between December 2019 and March 2020. We found that those rosters listed eight infants who should have been—but had not been—added to the CARES family composition records prior to our visits to the shelters.

Infants Missing from Required Records May Be at Risk

By not adding infants into the appropriate records in a timely manner, shelter staff increase the risk to the safety and wellbeing of the infants. The inclusion of that information in CARES helps enable DHS and the shelter staffs to provide appropriate services to families with infants, such as conducting timely unit inspections—weekly for families with infants, as opposed to bi-weekly for other residents. Additionally, DHS selects families for its semiannual review based on factors such as the presence of a newborn or crib age child. Consequently, inaccurate rosters, specifically those missing infants residing in shelters, may prevent DHS from selecting a family with an infant for its semiannual review or from taking other specific steps to ensure the safety of all families and infants within those shelters.

> ***DHS Response:*** "DHS disagrees with the auditor's use of the date of birth as a date of determining shelter entry." DHS also disagreed with the audit's inclusion of the 23 infants for which the auditors were not able to determine the exact entry date, as infants who are or may have been at risk. DHS argues that these infants may have been either at the hospital or residing with other family members the first days or weeks of the infant's life.
>
> ***Auditor Comment:*** For these 23 infants the report does not state, or specify the number of days by which, the entries were late. The infants' birth dates were used as reference points for the number of days that DHS was unaware of the infant's whereabouts. As indicated in the report, the records in CARES for the 23 infants lacked sufficient information to show whether the infant either *arrived* at the shelter or was *present* at the shelter for more than 7 days before the staff updated the family composition record. Just as we are unable to conclusively determine when the infants entered into shelter, DHS is likewise unable to make that determination. In fact, and

as explained in the report, 12 of these 23 infants were in the shelter up to 26 days before they were added to CARES.

DHS Response: DHS disagrees with the implication "that a time lag in data entry resulted in unsafe conditions." DHS takes issue with the audit's implication that the late entry for 20 infants is an indication that DHS is failing to ensure that infants are safe and are added to the case composition in a timely manner.

Auditor Comment: DHS incorrectly argues that a lag in entering infants to the family composition in CARES is insignificant to the infants' safety and wellbeing. As highlighted in our report, shelter staff were unaware of an infant's presence at the shelter at the time of our visit. That lack of awareness could prevent or delay the shelter from providing necessary services to the family (conducting required weekly unit inspections or enrolling the family in the visiting nurse program).

Recommendation

3. DHS should update, and enforce, its written policies and procedures to include a specific timeframe in which shelters must update their records in CARES, any successor system, and other records to account for the presence of all infants. The written policies and procedures should cover, at a minimum, updates to the family composition records, and a standard, readily searchable, contemporaneous record of the date every infant, including every newborn, begins residing in the shelter.

   DHS Response: DHS agreed with this recommendation, stating that "vendors should follow agency policies and procedures and that the safety of the infants is paramount" and that DHS will "require case note documentation to be completed within seven days of service provision or unit inspection. CARES will be updated to allow entry of the date infants actually arrive in shelter." However, DHS disagreed with the methodology and conclusion of the finding (discussed in prior sections of the report).

Inadequate Controls to Ensure Safe Sleep Practices, Appropriate and Safe Unit Conditions, and Timely Reporting of Infants in Residence

Two factors contribute to the lack of safety and increased health risks for infants at the shelters we visited, as well as to the untimely reporting of infants: (1) shelters are not diligent in informing families of safe sleep protocols; and (2) shelters do not consistently perform or document the required shelter inspections. These factors are further discussed in the following sections.

Shelters Visited Are Not Informing Families of Safe Sleep Protocols upon Infant's Arrival at the Shelter

One reason families may not be fully complying with the safe sleep requirements is that staff at the shelters we visited are remiss in informing families of safe sleep protocols. According to DHS' Safe Sleep Policy, within 48 hours of a family's entry into a shelter:

(1) Shelter staff must show a video to each family with a child two years of age or younger instructing them on safe sleep practices, such as maintaining uncluttered cribs, not sharing a bed with the infant, and placing infants on their backs.

(2) Families with infants younger than 12 months of age must complete and sign the safe sleep form, which documents whether they accepted or refused the shelter-provided crib and whether they were shown the safe sleep video.

As indicated in Table IV below, 12 of the 13 shelters visited were missing or had incomplete safe sleep forms for 53 of the 91 units we inspected (58 percent). For these 12 shelters, the deficiencies range from 30 to 100 percent of the units reviewed within the shelter.

Table IV

Number of Units with Missing or Incomplete Safety Forms

Shelter	# of Units Inspected	# of Units with Missing or Incomplete Forms	% of Units with Missing or Incomplete Forms That Also Had Sleep Safety Deficiencies	# of Units Missing Safe Sleep Forms	# of Units with Incomplete Safe Sleep Forms
HELP – Bronx Crotona	10	6	60%	1	5
University Family Center	10	3	30%	1	2
Bronx Neighborhood Aguila	10	6	60%	0	6
Urban Strategies	8	7	88%	0	7
Flagstone Family Services	9	5	56%	0	5
Jennie A Clarke	8	6	75%	3	3
Staten Island Family Center	1	1	100%	0	1
Bronx Bridge 1	4	0	0%	0	0
Community Outreach	2	1	50%	0	1
Manhattan Hotels	12	7	58%	4	3
Metro Family Residence	10	7	70%	0	7
New Dawn Hotel	4	3	75%	2	1
Belt Family Center	3	1	33%	0	1
Total	91	53	58%	11	42

As indicated above, we found that safe sleep forms were missing or incomplete at 12 of the 13 shelters we visited. These results are broken out as follows:

- Five shelters lacked evidence for 11 (12 percent) units indicating whether the shelters provided families with the safe sleep form, indicating whether the families accepted or refused the DHS-approved cribs.

- Twelve shelters had a total of 42 (46 percent) units with Safe Sleep Education Acknowledgment and Crib Acceptance/Refusal Forms that were either incomplete or incorrectly filled out.[9] Forms did not contain a date of arrival of the infant at the shelter and were missing acknowledgements as to whether the family accepted or refused the crib, the case manager's signature, or the family's signature. Forms also contained conflicting information regarding cribs; for example, some of the forms indicated that the family both accepted and refused the crib.

Moreover, despite the requirement that the forms must be signed no later than 48 hours from the time of the infant's arrival at the shelter, 23 families in 11 shelters (a total of 25 infants) signed the forms between 3 and 131 days late.[10]

Furthermore, although DHS updated and issued the current Safe Sleep Education Acknowledgment and Crib Acceptance/Refusal Form on February 12, 2018, we found that 9 of the 13 shelters visited still used the outdated forms for infants who entered the shelters between December 22, 2018 and January 10, 2020. The outdated forms lack two key elements that DHS incorporated into the new forms, specifically: (1) the date of an infant's arrival at the shelter, which, among other things, dictates the start of the weekly unit inspections; and (2) the family's acknowledgement as to their acceptance or refusal of the DHS-approved crib. A refusal would necessitate DHS' review and approval of the crib selected by the family. In continuing to use the outdated forms, these shelters increase the risk that infants may be placed into an unsafe environment.

In addition, as previously noted, in 33 (60 percent) of the units with safe sleep issues, the Safe Sleep Flyer was not posted anywhere in the unit.

In not providing safe sleep instructions and critical information to families on the proper use of cribs or ensuring that safe sleep flyers are posted, the operators of the above-mentioned shelters increase the risk that families may not be aware of safe sleep practices and, ultimately, may endanger the lives of infants.

During the exit conference, DHS officials stated that shelter staff continuously met with clients to discuss safe sleep protocols and referred to notations within the client case notes documenting these discussions. However, while continued reinforcement of safe sleep protocols is important, it is distinct from the mandatory requirement that families receive safe sleep instructions within the first 48 hours of the infant's arrival at the shelter and from the requirement that families attest to having been given this information by signing a safe sleep form. In addition, following the exit conference, DHS gave us additional safe sleep forms for nine of the cited deficiencies, of which we found only one to be appropriate evidence. Of the remaining eight forms: two pertained to siblings of the sampled infants (DHS requires that a form is signed for each child); one form was signed *before* the family entered shelter; one form related to a shelter different than the sampled one we visited; one form was for a shelter stay period considerably later than the period in our sample; and three forms appear to have been placed in the file subsequent to our visit to the sampled shelters.

[9] We found 79 forms in the files for 91 units. 52 of the 79 forms did not contain a date of arrival of the infant at the shelter. 45 of the 52 forms were missing this date because the shelter used an outdated form, which did not have a space for the arrival date, and the remaining 7 forms were missing this date because shelter staff did not fill out the designated space for this entry.

[10] For 9 infants, we were not able to assess whether the form was signed no later than 48 hours from the infant's arrival at the shelter due to the missing arrival date in the family's physical and CARES records. In addition, for the 23 forms signed late, 8 forms were late by 1 week; 6 forms were late by 2 weeks; 3 forms were late between 15 and 30 days; and 6 forms were late by over 30 days.

DHS Response: "DHS does not agree that there is an increased risk associated with using an earlier version of the safe sleep video and crib acknowledgment form. The content is substantially consistent. Additionally, DHS has redundancies built into our system related to safe sleep to ensure client exposure to the material."

Auditor Comment: The earlier version of the safe sleep and crib acknowledgment form does not contain the same information as the updated form, which was updated on February 12, 2018. As noted in the report, the earlier version of the form lacks two key elements that DHS incorporated into the new form, specifically: (1) the date of an infant's arrival at the shelter, which, among other things, dictates the start of the weekly unit inspections; and (2) the family's acknowledgement of its acceptance or refusal of the DHS-approved crib. The fact that the shelters we visited were still using the outdated information may have negatively impacted the services provided to the families.

In addition, despite the redundancies that DHS believes its system includes concerning safe sleep practices, the only means DHS identified to establish that families are aware of safe sleep practices are through the acknowledgement forms families sign upon entering the shelters and by requiring the shelters and families to carry out certain procedures. The audit found that those procedures were not being carried out at the shelters we visited. In the absence of evidence to the contrary, we have no basis to alter this finding.

Sampled Shelters Are Not Consistently Performing or Documenting Inspections

One reason families may not be fully complying with both safe sleep requirements and the requirement of maintaining their units in adequate condition is that staff at the shelters in our sample are not consistently performing or documenting unit inspections. DHS requires shelter providers to inspect on a weekly basis units with infants 0-12 months of age and units with families that have active Administration for Children's Services (ACS) cases.[11] The weekly inspections are supposed to ensure that the units are maintained in a satisfactory condition, that safe sleep practices are enforced, and that maintenance and repairs are performed when required. DHS also requires shelter staff to manually note the results of the inspections on Unit Inspection forms and to electronically document the results in CARES. The manual Unit Inspection forms must be maintained in the client case files, and all weekly unit inspection forms must also be kept in the shelter's critical files.[12] In addition, CARES notes must be labeled specifically as "Unit Inspection." DHS reviews the manual and electronic records when performing its semiannual review of each shelter.

We found limited oversight by the providers of the sampled shelters to ensure that the units are inspected on a consistent basis. The lack of proper inspections may have allowed the safety and health deficiencies we observed to occur, go undetected, and remain uncorrected. As illustrated

[11] An open ACS case exists when a family receives prevention assistance services from ACS as a result of allegations made against the family for child abuse and/or neglect.

[12] Shelters must maintain a case file for each family and collect certain documents in a critical file. The family case file contains documents related to the specific family, such as birth certificates, copies of unit inspections, any notes made about the family by case workers, income and employment documentation, school records, etc. Critical files contain current documents related to the security of the shelters and the families residing in them. Examples of critical file documents include weekly unit inspections for families monitored by ACS, fire drill records, sprinkler testing, or fire alarms testing.

in Table V below, none of the 13 shelters we visited documented all required inspections either in CARES or on the Unit Inspection forms that should have been in the physical files.[13]

TABLE V

Summary of Unit Inspections That Were Not Documented Correctly and That Were Not Documented Anywhere

Shelter	# of Units in Sample	**# of Required Inspections for Sampled Units**	Inspections Documented either on Unit Inspection Forms or in CARES Notes	Inspections Not Documented Anywhere
HELP – Bronx Crotona	10	213	21	150
University Family Center	10	112	53	30
Bronx Neighborhood Aguila	10	172	31	82
Urban Strategies	8	160	55	24
Flagstone Family Services	9	199	37	109
Jennie A Clarke	8	99	45	47
Staten Island Family Center	1	6	6	0
Bronx Bridge 1	4	30	3	0
Community Outreach	2	34	22	12
Manhattan Hotels	12	167	65	38
Metro Family Residence	10	143	19	107
New Dawn Hotel	4	92	48	5
Belt Family Center	3	54	7	34
Total	91	1,481	412 (28%)	638 (43%)

In total, the 13 shelters visited should have conducted 1,481 unit inspections for the 91 families in our sample. However, the shelters documented only 431 (29 percent) of the required unit inspections both in CARES and on the physical inspection forms. As indicated in the table above, we found no evidence that the shelters conducted 638 (43 percent) of the required inspections, and 412 inspections had only one of the two forms of evidence to support the inspections—245

[13] We reviewed CARES entries and Unit Inspection forms within the physical files maintained by 13 shelters for 91 sampled families. Due to conditions and concerns regarding the COVID-19 pandemic in March 2020, the audit team was unable to complete inspections in seven additional shelters.

were documented only in CARES and 167 were documented only on the physical Unit Inspection forms.[14]

Of even greater concern, 18 of the families whose units were not consistently inspected had active ACS cases during the period we reviewed, and, accordingly, staff at the shelters where they resided should have inspected their units weekly even if no infants had been residing in them. Thus, in these cases the shelters' failure to conduct weekly inspections of the units violated DHS protocols relating to two specific risk factors—the presence of an infant and the existence of an active ACS case in each family—and may have increased the risk to these infants' health and safety. Conducting regular and timely inspections is all the more critical to ensure that all of the children in these circumstances remain safe and are not exposed to additional risks while residing in DHS-contracted shelters.

We also expanded the review of CARES records for an additional seven shelters that we initially planned to visit but were unable to conduct a complete review due to restrictions put in place during the COVID-19 pandemic. However, in areas of the review that we were able to complete, we found that required inspection records were missing from CARES notes for all seven shelters. While 806 inspections should have been conducted for 45 units in the seven shelters, 389 (48 percent) of the required inspections were not noted in CARES, casting doubt as to whether they took place.[15]

In addition to the lack of evidence for unit inspections, specifically, the absence of the required electronic and paper reports, the CARES reports, when done, were often delayed. For the 20 sampled shelters (the 13 we visited and the 7 additional shelters whose CARES records we reviewed), we found that the shelters entered the unit inspection reports into CARES on average 7 days, and as long as 99 days, after the dates of inspection. Although DHS directives are clear as to the *type* of documentation that shelters must maintain for each unit inspection, they do not stipulate a timeframe in which the shelters must enter the inspection reports into CARES. Given the amount of detail DHS requires for each unit inspection, it is not reasonable to expect that shelter staff will remember those details days or weeks later, especially when they do not record them during the inspections in hand-completed paper reports or notes, as is often the case.

Updating CARES promptly preserves the inspection's integrity and helps ensure that details are recorded accurately. Delays in recording the inspections can lead to shelter staff's entering inaccurate or incomplete information. Further, as stated by the Associate Commissioner for Transitional Family Services, DHS' monitoring unit uses CARES to complete routine reviews of shelters' overall services, including unit inspection notes concerning deficiencies and in determining whether shelters addressed those deficiencies. The sampled shelters' delays in recording unit inspections in CARES interfere with DHS' ability to adequately oversee such inspections and to offer meaningful assistance.

Results of DHS' Semiannual Reviews of Visited Shelters

Pursuant to DHS policy, the agency's program analysts complete semiannual reviews to track whether shelters are in compliance with applicable rules regarding shelter conditions and procedures. For each shelter, DHS program analysts sample either 10 percent of the units or 10

[14] We calculated the 1,481 unit inspections by determining the number of weeks that the infants from all 91 families resided in the shelter at the time of our observation. The amount of time an infant resided in a shelter ranged anywhere from one week to 44 weeks.
[15] Due to the outbreak of COVID-19, we were unable to visit these seven shelters and inspect the Unit Inspection forms filed by the shelters in the client files.

units within a facility, whichever is greater.[16] Subsequent to each inspection, DHS reports the results of the inspection findings to the shelters by issuing a letter summarizing the results, as well as the details of the monitoring instrument. Shelters cited for noncompliance are required to submit a Corrective Action Plan (CAP) within 30 days of notification, in which they list actions taken to address the issues noted or provide an estimated date by which corrective action will be taken.[17]

We analyzed the results DHS recorded in its Monitoring Instrument forms from its semiannual review conducted in the first half of Fiscal Year 2020 for the 13 shelters we visited, along with the contents of letters DHS issued to the providers requiring CAPs as a result of these reviews. Our analysis showed that in the areas of reporting newborns, inspecting units, and documenting safe sleep education and crib assignments, DHS' findings were very similar to ours:

- DHS cited 10 of the 13 shelters we visited for not maintaining weekly Unit Inspection forms in the files associated with 59 families. In fact, DHS found that one provider did not document unit inspections for 12 of the 17 files that DHS reviewed (71 percent).
- DHS found that 8 of the 13 shelters we visited were missing the required Safe Sleep Education Acknowledgment and Crib Acceptance/Refusal Forms for 20 families.
- DHS found that 10 of the 13 shelters we visited were missing hard copy Newborn Indicator forms for 30 of its 43 sampled families with infants.

DHS officials stated that the semiannual review is its way of ensuring that, among other things, shelters create and maintain an environment safe for infants. However, although DHS shares with the shelter management all details of the reviews recorded on the DHS monitoring instrument, providers are only required to respond to the findings included in the letter. Our cursory review found that the letters DHS issued to the providers requiring CAPs lacked many of the specifics noted above, such as shelters' failures to maintain weekly Unit Inspection forms, missing Safe Sleep Acknowledgement and Crib Acceptance/Refusal Forms, and missing Newborn Indicator forms. When DHS fails to formally include the specific issues found during its semiannual reviews in its letter, the effectiveness of those reviews as a means of monitoring—and ideally spurring improvement of—shelter conditions and operations is reduced.

DHS officials stated that when a provider receives low scores on the semiannual review, DHS lowers the vendor's rating on the NYC vendor database and that this rating is considered when existing contracts are reviewed for possible extension and when the provider is under consideration for new contracts. However, the providers for 5 of the 13 shelters we visited at about the midpoint of Fiscal Year 2020 received overall scores of "poor" on their reviews for the second half of Fiscal Year 2019, including one that received a score of "poor" three times and one score of "unsatisfactory" in four consecutive reviews. Four of those five shelters nevertheless continued to operate and do business with the City. In June 2020, DHS closed one of the locations of the fifth shelter. According to DHS, the location was closed as part of its efforts to reduce the use of

[16] Twice a year, DHS program analysts select 10 families from each shelter for the review. These families are chosen to represent the different types of families or cases that the particular shelter services. Families with infants are one of the types and as long as the shelter houses such families, the program analyst must ensure that a portion of the 10 samples is dedicated to families with infants.
[17] Subsequent to the inspections, DHS reviews CARES to determine whether the shelter addressed these issues and checks for these issues again during the following semiannual review. Occasionally, DHS also visits shelters in between the semiannual reviews.

non-contracted shelters and commercial hotels, rather than as consequence of poor performance.[18]

Effective controls are vital in helping to ensure that shelter providers maintain their facilities in satisfactory condition and address safety and health concerns in a timely manner. To the extent the conditions found at these sampled shelters are also found at the remaining shelters contracted by DHS, there is an increased risk that providers managing shelters throughout the City may be offering inadequate housing to homeless families.

Recommendations

4. Shelter staff should ensure that they play the prescribed safe sleep instructional video for all families with infants and then obtain properly completed Safe Sleep Education/Acknowledgment and Crib Acceptance/Refusal Forms on time from all families with infants and that they use only the updated form DHS prescribes.

   DHS Response: DHS agreed with this recommendation, stating that "shelter providers should ensure that they play the safe sleep instructional video." In addition, DHS has "updated and resent the updated materials and acknowledgement forms and directed vendors to use them." However, DHS did not agree with the conclusion of the audit's finding with regard to using outdated safe sleep forms and felt that DHS had "redundancies" built into its system related to safe sleep (discussed in prior sections of the report).

   DHS also listed other elements of its Safe Sleep campaign, which are designed to help shelters maintain a safe sleep environment for infants, stating that:

   "As we told the auditors, in November 2019 DHS' Office of the Medical Director conducted focus groups in Families with Children shelters with parents of infants to assess our client's awareness of safe sleep materials and whether using technology would be welcomed as part of the safe sleep messaging. All participants in the focus groups reported having seen safe sleep materials and were aware of the risks of not following safe sleep practices.

   DHS' Safe Sleep campaign represents an effort to increase awareness in our clients of safe sleep practices. DHS works to ensure client exposure to this material as a service to our clients, but we disagree that less than 100% documented client exposure to this material equates to a failure on the part of DHS shelter providers to adequately ensure the safety and well-being of infants residing in shelter. To approach client awareness campaigns in this way would create a disincentive for City agencies to try innovative client awareness campaigns in general. Nor can DHS sanction families for failure to follow safe sleep practices, as all families in New York City have the right to self-determination regarding their sleep arrangements. Nevertheless, DHS will continue with this awareness campaign, as we believe the 59% decrease in infant deaths in our system in FY19 is significant and a clear indication that our efforts are moving in

[18] This shelter operates at multiple locations. The families in our sample resided at seven locations. DHS closed one of these locations on June 2, 2020.

the right direction – at the same time, we recognize that more work needs to be done to drive this number down further.

Auditor Comment: As stated earlier, our audit scope did not include an assessment of DHS' monitoring of the shelters, so we are unable to comment on the adequacy of its Safe Sleep Campaign or assess the results of its findings. We did, however, note that DHS requires shelters to play the prescribed safe sleep instructional video for all families with infants and to obtain properly completed Safe Sleep Education/Acknowledgment forms from those families, for which we found compliance to be lacking at the shelters we visited.

Moreover, while we acknowledge that families have a right to self-determination, DHS has a responsibility to take all appropriate efforts to ensure that its safe sleep protocols are implemented to help reduce the risk that an infant's life may be in danger. We therefore commend DHS for recognizing that more work needs to be done to drive the number of infant deaths down further and for agreeing to implement this recommendation.

5. Shelter staff should ensure that they perform the required weekly unit inspections, take prompt corrective action to address the deficiencies found, and document the results in a timely manner.

DHS Response: DHS agreed with this recommendation, stating DHS "will update [its] policy to include a specific timeframe in which shelters must update their records in CARES to document unit inspections.

DHS policy for the time frame to document unit inspection will be updated to reflect one week from unit inspection completions."

6. DHS should establish and enforce timeframes for shelter providers to record the dates and results of their inspections in CARES and any successor system that may be established and in the applicable paper files.

DHS Response: DHS agreed with this recommendation, stating that "DHS distributed a standardized form for unit inspections to upload into CARES, which is a requirement. The form has a date to record when the inspection was completed, and work orders submitted. Case notes that are entered are time stamped. Weekly Case Reviews of Infants in shelter by the DHS Team is now a requirement to reinforce provider compliance."

7. DHS should stress to shelter providers the significance of instructing all families with infants on safe sleep policies and providing all families with infants with safe cribs.

DHS Response: "DHS agrees that this is necessary but disagrees that this is not already being done.

This is currently a requirement that must be completed at intake and subsequent weekly unit inspection discussion, as reflected in the Infant Safe Sleep Advisory

for parents and staff, 2018 Safe Sleep Policy, and Understanding the Monitoring Instrument. DHS has also stressed safe sleep awareness during our quarterly shelter director meetings."

Auditor Comment: Despite DHS' assertions that it is already in compliance with this recommendation, as our audit indicated, the proper Safe Sleep documentation was missing or incomplete for more than half of sampled families, suggesting that shelter providers are not following the Safe Sleep protocols.

Accordingly, we urge DHS to redouble its efforts and implement this recommendation.

8. DHS should reinforce with shelter providers the significance of performing the required number of unit inspections in accordance with the prescribed frequency standards.

DHS Response: "DHS agrees that reinforcing this requirement is necessary but does not agree that this is not already being done.

DHS continues to reinforce this expectation to providers during daily calls that are led by DHS program administrators. Shelter directors attend these calls. DHS also stresses this in quarterly Shelter Director Meetings, case record reviews by Compliance Analysts, Program Administrator weekly reviews, and system wide email communications, most recently on January 27, 2020 and August 25, 2020. Program Analysts also reinforce unit inspections during their completion of Bi-Annual Monitoring Instrument."

Auditor Comment: Despite DHS' assertion that it is already in compliance with this recommendation, our audit found that 43 percent of the unit inspections were not documented in either the family physical case files or in CARES, suggesting that shelter providers are not following the unit inspection protocols.

Accordingly, we urge DHS to reconsider its response and to implement this recommendation.

9. DHS should reassess the degree to which the semiannual review adequately addresses issues of infant safety in its shelters for families with children and consider taking steps to place more emphasis on this topic and elicit additional details in its reviews and records of them. Further, DHS should reconsider the detail with which it reports the deficiencies and other issues it identifies through its reviews in its letters to providers and consider reporting them in greater detail and requiring the providers to submit CAPs in corresponding detail.

DHS Response: DHS disagreed with this recommendation stating, "The Bi-annual Monitoring Instrument Inspection has a series of questions dedicated to infant safety, in addition to the DHS Universal Inspection Form.

The Monitoring Instrument report is also shared with the provider, not just a summary letter of the bi-annual inspection. The tool reflects all findings of each

hardcopy chart review and CARES review findings. Additionally, this includes case record review findings, unit inspection findings, and infant safety. DHS providers are expected to submit corrective action plans for all deficiencies identified during an inspection, not just those listed in the summary cover letter."

Auditor Comment: As indicated in our audit report, our analysis of the findings noted on DHS' Monitoring Instrument form showed that in the areas of reporting newborns, inspecting units, and documenting safe sleep education and crib assignments, DHS' findings were very similar to ours – a clear indication that the mere existence of the monitoring tool was not sufficient to ensure that shelters consistently created and maintained a safe environment for infants. Consequently, DHS needs to reassess current practice and consider taking additional steps to ensure that safe environments are provided to infants.

In addition, as conveyed to us by two DHS officials on two separate occasions, although DHS shares with the shelter management all details of the reviews recorded on the DHS monitoring instrument, providers are only required to respond to the findings included in the letter. This process is also detailed in DHS' Program Analyst Manual. Our review of the letters that DHS issued to those providers requiring CAPs confirmed that the letters lacked many of the specific details that shelters should have been apprised of—and required to address—in order to take meaningful corrective action. The missing details pertained to areas such as shelters' failures to maintain weekly unit inspection forms, missing Safe Sleep Acknowledgement and Crib Acceptance/Refusal Forms, and missing Newborn Indicator forms. The lack of such specifics in the responses DHS requires from the shelters diminishes the effectiveness of DHS' semiannual review and fails to ensure that the shelters properly identify and correct the deficiencies.

Accordingly, we urge DHS to implement this recommendation.

10. DHS should establish and enforce consequences for noncompliance with infant safety policies.

DHS Response: "DHS agrees that strengthening enforcement is necessary but does not agree that significant compliance and enforcement efforts have not already been made."

DHS established the Shelter Compliance Procedure to address on-going performance concerns, and then issued it on June 29, 2018. This procedure was shared with the auditors on September 9, 2020.

Nevertheless, DHS agreed to implement the recommendation, stating that "to improve accountability of our providers, DHS is developing an elevated compliance plan for providers who are consistently found to perform poorly during our bi-annual monitoring activities."

Auditor Comment: Our audit findings belie DHS' assertion that it was addressing ongoing performance concern. Despite its establishment of Shelter Compliance

Procedures, the shelters we visited did not carry out DHS policy and procedures on a consistent basis and we found no evidence of any action taken by DHS. We are therefore pleased that DHS recognizes the need for strengthening enforcement and has agreed to implement this recommendation.

DETAILED SCOPE AND METHODOLOGY

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objective. This audit was conducted in accordance with the audit responsibilities of the City Comptroller as set forth in Chapter 5, §93, of the New York City Charter.

The scope of this audit was July 2018 through March 2020.

To obtain an understanding of DHS' policies that govern the safety and wellbeing of infants residing in homeless shelters, we reviewed DHS' policy DHS-PB-2018-01 "Safe Sleep Policy on Infants in Shelters for Families with Children," its Program Analyst Manual, and its "Understanding the Monitoring Instrument" publication.

Additionally, we met with the Deputy Commissioner of Family Services; Associate Commissioner and two Assistant Commissioners for Transitional Services; Assistant Commissioner and Administrative Director for Eligibility and Investigations for PATH; and DHS' Medical Director. To obtain an understanding of CARES, DHS' system that collects client information and services provided by shelters, as well as the monitoring techniques DHS uses to ensure that shelters follow standards and regulations, we met with program analysts of Family Transitional Services.

We reviewed a list of 157 shelter facilities that house infants at 308 locations received from DHS and determined the reliability of this data by checking for duplicates and assessing completeness by matching facility codes on the list to the ones noted on the report of family shelters in CARES.[19] We also verified whether there were any families with children placed in shelters that were not on the list and whether any children resided in shelters not designated for families with children.

From the list of 308 locations, we judgmentally selected three locations that had the highest number of infants residing at the shelters as of May 30, 2019. The three locations represented the three types of family shelters - cluster, Tier II, and commercial hotel. We interviewed shelter staff and upper management to learn: (1) what measures shelter providers take to fulfill their responsibilities in ensuring the safety and wellbeing of infants, as mandated by DHS, and (2) whether different types of family shelters were required to follow different infant safety regulations.[20]

We excluded these three locations from further testing and, as a result, were left with a population of 305 locations related to 156 shelter facilities, housing 11,839 families with 1,597 infants. From this list, we initially selected 11 randomly selected shelters and later expanded our sample by randomly selecting nine additional shelters, for a total sample of 20 shelters.[21] Further, for each

[19] DHS compiled the list as of May 30, 2019. Some of the shelter facilities had multiple locations.
[20] We learned that all shelters, despite their structure, were required to follow the same infant safety rules, and DHS' expectation is that all shelters document these tasks in an identical way.
[21] To ensure that the number of selected shelters was proportionate to the number of shelters within each borough, we first calculated the ratio of shelters within each borough. Then, starting with the borough with the most shelters, we randomly selected the prorated number of shelters. Also, to ensure that our selection did not contain multiple shelters for one provider, we excluded providers that were already selected. As a result, our sample selection included one shelter in Staten Island, two in Queens, four in Brooklyn, four in Manhattan, and nine in the Bronx.

sampled shelter, we randomly selected the roster in CARES for either 10 percent of families with infants, 10 families with infants, or all families with infants, whichever of the three categories yielded the highest number.

We visited 13 of the 20 shelters. (Due to restrictions imposed in response to the COVID-19 pandemic, we were restricted from completing visits to the remaining seven shelters in our sample.) Based on the above-described methodology, we performed the following tests for the 91 families with 94 infants residing within the shelters:[22]

- Inspected the physical premises by conducting unit inspections to assess the safety and physical condition of each unit and to determine whether these conditions were in any way harmful to infants.
- Reviewed Safe Sleep Education Acknowledgment and Crib Acceptance/Refusal Forms maintained in the physical records to assess the degree to which shelters followed DHS' safe sleep procedures.
- Reviewed Unit Inspection forms filed in client physical files as well as CARES records to assess whether the shelters conducted the weekly unit inspections and documented the results.

Furthermore, in addition to the 13 randomly selected shelters with 91 units, we expanded our review of unit inspections to include seven randomly selected shelters with 45 units for the review of notes recorded within CARES with regards to the inspections, for a total of 20 shelters, with 136 units, housing 140 infants.

Based on our review of CARES records, we found that 96 of the 140 randomly selected infants in the 20 sampled shelters were born while the family resided in the shelter. In addition, we identified eight infants born while the family resided in the shelter but who were not added to the roster as of the time of our visit. We selected these 104 infants to determine whether shelter staff updated the family composition record in a timely manner. We reviewed CARES records for all 104 infants and the physical case files for 67 of the infants from shelters we visited.

Finally, to assess DHS' monitoring of infant safety in homeless shelters, we reviewed the Monitoring Instrument forms prepared by DHS program analysts for the first half of Fiscal Year 2020, as well as the corresponding CAP letters sent to the 13 shelters we visited. We also reviewed the CAP letters DHS issued to the shelters for the first part of Fiscal Year 2020 in order to determine whether DHS employs adequate measures to report the uncovered issues to the providers.

The results of the above tests provided a reasonable basis for us to assess whether providers of sampled homeless shelters designated for families with children adequately ensured the safety and wellbeing of infants.

[22] We initially selected a total of 140 infants from 136 families residing at 20 shelters; however, due to the emergency situation caused by the outbreak of COVID-19, we were unable to complete some designed tests of the 20 sample shelters.

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Human Resources Administration
Department of Homeless Services

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December 07, 2020

Ms. Marjorie Landa
Office of the City Comptroller
1 Centre Street, Room 1100
New York, NY 10007

Re: Agency Response to the Draft Audit Report on the Safety and Well-being of Infants Residing in Sampled Department of Homeless Services Shelters MG19-110A

Dear Ms. Landa,

Thank you for sharing the draft report for the New York City Comptroller Office's Audit of Safety and Well-being of Infants Residing in Sampled Department of Homeless Services Shelters (MG19-110A).

Please find enclosed our response in the form of a corrective action plan which identifies actions already implemented, and those that will be implemented, to address issues you have noted in your report. The corrective action plan also identifies draft findings that are incorrect, and we ask that the final report be revised accordingly.

As an initial matter, we have always valued the collaborative work with the Comptroller's Office to improve our performance and client services. In this particular audit process, however, we are concerned that the determination to exclude DHS staff from the site visits and then the substantial delay in providing DHS staff with the site visit observations impeded the agency's ability to take immediate action to remedy deficiencies. We urge you to rethink this approach. Fortunately, while the audit was pending and before DHS received information from the auditors, DHS staff took independent action to address many of the issues in the normal course.

With respect to specific draft findings themselves, they do not acknowledge the facts and information that DSS/DHS presented demonstrating that the agency makes every effort to share important health and safety information with clients and will continue to stress the importance of working with clients on such issues to help prevent tragic deaths from unsafe sleeping. Indeed, the draft findings fail to report a fact that is essential for the public to understand in considering the accuracy of the Comptroller's audit – beginning in FY17, and particularly through redoubled efforts in FY19, the agency's initiatives first drove down the number of infant deaths by more than half in FY20 (down to seven), and then have achieved zero Safe Sleep-related deaths in FY21 to date based on preliminary data. Likewise, the draft findings do not even mention that the agency has built in redundancies to make sure that families receive safe sleeping information, including but not limited to:

- All new families and all pregnant applicants are assessed at PATH Family Intake, evaluated for unique needs, and connected with relevant resources, including as

relates to parenting, infant safety, and Safe Sleep. Based on those individualized assessments, the medical clinic at PATH connects families to relevant resources and provides informational materials related to childbirth, Safe Sleep, parenting tips/guidance, maternal health, and care coordination, including linkages to off-site services and assistance navigating through healthcare system.

- Furthermore, the PATH Intake Center has the Safe Sleep video playing on a loop in the waiting areas for clients to see. We also have a partnership with DOHMH to provide the Newborn Home Visiting Program to all families with infants who reside in shelter. Safe Sleep is an educational component of this program.
- We also worked in partnership with ACS' Child and Family Well Being Division to design/enhance Safe Sleep training for staff whose roles involve serving and supporting families experiencing homelessness, with a focus on communicating comprehensive Safe Sleep information effectively and directly to clients, building trust, and emphasizing health and safety.
- In addition to regularly and proactively sharing educational materials/making these materials readily available, shelter staff also distribute resources like Pack and Plays and wearable blankets, which promote safe sleep practices, offering these vital resources to all families at no cost.

Our proactive focus groups to ensure these reforms are taking hold and having a positive impact on families' health and wellbeing confirm that families are receiving this information. The draft findings also reflect a misunderstanding of the timing of when newborns may begin to reside in a shelter in certain cases and do not acknowledge the range of interventions we have designed, including in partnership with other City Agencies, to ensure we are offering all families the support they need, such as the assignment of nurses to support families with newborns in partnership with the Department of Health and Mental Hygiene, as well as the Newborn Home Visiting Program.

The draft report also fails to recognize that many providers who were audited have proven track records of providing excellent shelter services for clients, while others are being phased out as part of a publicly reported effort to transform the shelter system by raising the bar. These are important facts that would contribute to the public's understanding of the safe sleeping issue.

Likewise, as the auditors surely know, safe and unsafe infant sleeping are broader societal issues that affect families across a wide range of income levels. The failure to acknowledge this reality does not contribute to public discourse on this important issue and stigmatizes the agency's clients for independent decisions that they may make just as families with higher income do, albeit with tragic consequences that we are working every day to prevent.

The agency remains committed to its mission of serving New York City's most vulnerable families and individuals in the most efficient and effective manner, while adhering to all applicable rules, regulations and laws by which we are bound. We would like to express our sincere appreciation for the efforts that your office has invested to assist us in achieving our goals.

We are confident that our progress and our response to this audit demonstrates the agency's commitment to continually improving our operations. Should you have any questions

regarding the enclosed, please contact Sonia Lamrhari, Director of the DSS Bureau of Audit Coordination at 929-221-5724.

Thank you for your consideration.

Yours sincerely,

Christine Maloney

Christine Maloney
Interim Deputy Commissioner, Office of Audit & Quality Assurance Services

Enclosures

NYC DEPARTMENT OF SOCIAL SERVICES
OFFICE OF AUDIT SERVICES
CORRECTIVE ACTION PLAN

Audit Name: Draft Audit Report on the Safety and Wellbeing of Infants Residing in Sampled Department of Homeless Services Shelters
Audit Number: MG19-110A

Date: December 07, 2020

Auditor's Recommendations	Agency Response	Responsible Unit	Agency Corrective Action	Target Date
Recommendation 1: DHS should ensure that shelter providers consistently and in a timely manner perform all of the required inspections of each unit.	Agree DHS agrees that it is important to ensure that shelter providers consistently and in a timely manner perform all required unit inspections. We currently monitor for timely unit inspections and include consistency in that monitoring. It is with this in mind that we standardized the unit inspection form for our providers in January of 2020. We also currently require corrective action plans when we identify this as a deficiency during our bi-annual monitoring. In addition to our twice annual monitoring activities, DHS has now added weekly random case note reviews to ensure that unit inspections are occurring and are being documented, using the standardized tool introduced in January 2020. This is now occurring for all of our shelter.	DHS Program-FWC	Create standardized unit inspection forms. Conduct weekly case note reviews.	**Completed January 2020** **November 2020/Ongoing**
Recommendation 2: DHS should ensure that the shelter providers promptly inspect and correct the unresolved conditions that raise safety and health concerns in the sampled shelters identified in this report.	Partially Agree DHS agrees with most of the conditions noted in the audit report, and we have required our providers to inspect and correct all conditions. We have also strengthened our monitoring for inspections, as noted above in Recommendation 1.	DHS Program-FWC	See Recommendation **1.**	

Audit Name: Draft Audit Report on the Safety and Wellbeing of Infants Residing in Sampled Department of Homeless Services Shelters
Audit Number: MG19-110A

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	DHS disagrees with the implication in the report that unresolved conditions were not timely addressed. Vendors were placed on Corrective Action Plans requiring remediation as soon as we became aware of findings. In this we respect we note some conditions in the audit report were listed in the general category of "Unit Needs Repairs", and the specifics needed to take corrective action were not shared with DHS until after the draft audit report was issued. At that point, on October 19, 2020, the auditors shared specifics of the items, close to one year after the auditors' observations. It is important to note that DHS staff were excluded from attending the NYCC inspections which gave rise to the findings. The provider staff who accompanied the auditors were not DHS staff. The staff were employees of providers who contract with DHS to operate shelters or who are brought in by landlords to operate shelters that are not contracted. Including DHS staff in the inspections would have enabled DHS staff to ensure that all items were remediated in real time; or if DHS had been given immediate notice of the conditions by the auditors, immediate action could have been taken. By not permitting DHS staff to be present during these inspections, and by not informing DHS of the observations generally or specifically until a minimum of 239 days after the inspections in some cases, and up to almost one year in other		Ensure providers comply with DHS' Corrective Action Plans.	**Completed/ Ongoing**

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	cases, the auditors delayed DHS' ability to effectively address concerns. We note that in some cases, including the case of rodent droppings in a crib, DHS, without assistance from the auditors in identifying the condition, had already required that the condition be remediated and the provider was directed by DHS to create a corrective action plan on January 17, 2020. This was eight months prior to the auditors sharing the specific conditions with DHS. Additionally, for the conditions that were observed in shelters that DHS closed, these shelters were closed prior to the auditors sharing their observations with DHS. With respect to the specific deficiencies in the draft report, DHS notes the following: • DHS will instruct providers to work with families who have moved cribs near heat sources or outlets or near exits to not place the cribs in those locations. • DHS has directed providers to work with families to not place hazardous products like cleaning supplies and laundry detergent within reach of infants.			

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	• Given that families in shelter clean their own units, DHS has directed providers to continue working with families on basic housekeeping skills, which include mopping, using proper garbage receptacles, and not storing food in the open, which attracts vermin. • Extermination services were required where vermin were present. • DHS will require providers with radiator covers that are sharp to file the edges. This will be completed by December 15, 2020. • Health and safety concerns raised by the auditors include windows that are not insulated. DHS has requested the specific Building Code section related to the use of single pane windows that is the basis for this finding, but DHS has not yet received it from the auditors. This condition is included in the auditor's category of non-addressed conditions. However, current local laws do not require an existing building with single pane windows to change to double pane windows if no work is planned; older buildings that have single pane windows do not receive violations for not having double pane windows. The trigger for this			

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	requirement is any proposed major alteration to the building envelope (exterior) or direct replacement of window(s). Proposed or replaced windows, then need to meet Energy Code Requirements and provide double pane windows to comply. • The heat condition noted on page 20 is an example of why it would be so important for DHS staff to accompany auditors on inspections, as this would have allowed DHS to hold the provider immediately accountable to ensure that condition was remediated promptly, instead of learning about the heat condition the following August, several months after it was noticed by the auditors and well after heat season had ended. • Exposed outlets at one shelter is a condition the auditors included as not addressed. This shelter uses tamper resistant outlets. DHS obtained the purchase receipts for tamper resistant outlets from the provider showing the purchase was made months before the audit. DHS shared these with the auditors, but they were not accepted as proof of installation. These tamper resistant outlets look like regular outlets unless they are closely inspected, which DHS has done to confirm their presence in the units which were inspected by the auditors.			

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Recommendation 3: DHS should update, and enforce, its written policies and procedures to include a specific timeframe in which shelters must update their records in CARES, any successor system, and other records to account for the presence of all infants. The written policies and procedures should cover, at a minimum, updates to the family composition records, and a standard, readily searchable, contemporaneous record of the date every infant, including every newborn, begins residing in the shelter.	Partially agree DHS agrees that vendors should follow agency policies and procedures and that the safety of infants is paramount. However, DHS disagrees with the auditors' use of the date of birth as the date for determining shelter entry, or that a time lag in data entry resulted in unsafe conditions. Some infants remain either in the hospital for varying periods of time or spend time at residences of extended family members prior to joining families who reside in shelter. For this reason, infant birth dates are not a consistent indicator for shelter entry. The auditors determined that 20 of the 104 infants were added to the family case compositions later than seven days after entry in shelter. The auditors were not able to determine that 23 cases were added after seven days of shelter entry. These infants may well have remained in the hospital or entered shelter later than seven days after birth. This means the auditors found that 19% of the infants in their audit were added after seven days of shelter entry and were not able to determine that the remaining 81% had been added to case compositions after seven days of shelter entry. DHS will always work to improve an 81% compliance level, but DHS does not agree that the 19% of cases that were added after seven days indicate that DHS is failing to ensure that infants are safe and added to the case composition in a timely manner.	DHS Program-FWC OPPT OPDI	DHS will require case note documentation to be completed within seven days of service provision or unit inspection.	**November 2020/Ongoing**

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	DHS will require cases note documentation to be completed within seven days of service provision or unit inspection. CARES will be updated to allow entry of the date infants actually arrive in shelter.		DHS Policy will be updated to reflect case note documentation requirements. Update CARES system to capture the date of infant's entry into the shelter.	**December 2020** **June 2021** (subject to funding during the fiscal crisis)
Recommendation 4: Shelter staff should ensure that they play the prescribed safe sleep instructional video for all families with infants and then obtain properly completed Safe Sleep Education/Acknowledgment and Crib Acceptance/Refusal Forms on time from all families with infants and that they use only the updated form DHS prescribes.	Partially Agree DHS agrees that shelter providers should ensure that they play the safe sleep instructional video, as this is part of our Safe Sleep campaign. In early 2019, DHS launched a safe sleep campaign (awareness and education, training, and distribution of pack 'n play beds) which we believe led to the subsequent decrease in infant deaths. In FY20, we saw a 59% decrease (n=7) compared to FY 19 (n=17). FY21 is on track to maintain that decrease. DHS does not agree that there is an increased risk associated with using an earlier version of the safe sleep video and crib acknowledgement form. The content is substantially consistent.	DHS Program-FWC	Ensure providers play the Safe Sleep instructional video.	**Ongoing**

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	Additionally, DHS has redundancies built into our system related to safe sleep to ensure client exposure to the material. Over the past several years, we've implemented significant reforms and strengthened processes at the PATH Intake Center to ensure families are proactively provided with these resources. For example, at PATH effectively providing services and supports to families as they get back on their feet is our number one priority—and that includes ensuring expectant as well as new mothers have access to medical care, targeted services/resources, and necessary information related to childbirth, health and safety, expectations, and who/where to seek additional assistance. All new families and all pregnant applicants are assessed at PATH Family Intake, evaluated for unique needs, and connected with relevant resources, including as relates to parenting, infant safety, and Safe Sleep. Based on those individualized assessments, the medical clinic at PATH connects families to relevant resources and provides informational materials related to childbirth, Safe Sleep, parenting tips/guidance, maternal health, and care coordination, including linkages to off-site services and assistance navigating process through healthcare system. Furthermore, the PATH Intake Center has the safe sleep video playing on a loop in the waiting areas for clients to see. We also have a partnership with DOHMH to provide the Newborn Home Visiting Program to			

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	all families with infants who reside in shelter. Safe Sleep is an educational component of this program. We also worked in partnership with ACS' Child and Family Well Being Division to design/enhance Safe Sleep training for staff whose roles involve serving and supporting families experiencing homelessness, with a focus on communicating comprehensive Safe Sleep information effectively directly to clients, building trust, and emphasizing health and safety. In addition to regularly and proactively sharing educational materials/making these materials readily available, shelter staff also distribute resources like Pack and Plays and wearable blankets, which promote safe sleep practices, offering these vital resources to all families at no cost. As we told the auditors, in November 2019 DHS' Office of the Medical Director conducted focus groups in Families with Children shelters with parents of infants to assess our client's awareness of safe sleep materials and whether using technology would be welcomed as part of the safe sleep messaging. All participants in the focus groups reported having seen safe sleep materials and were aware of the risks of not following safe sleep practices. DHS' Safe Sleep campaign represents an effort to increase awareness in our clients of safe sleep practices. DHS works to ensure client exposure to this material as a service to our clients,			

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	but we disagree that less than 100% documented client exposure to this material equates to a failure on the part of DHS shelter providers to adequately ensure the safety and well-being of infants residing in shelter. To approach client awareness campaigns in this way would create a disincentive for City agencies to try innovative client awareness campaigns in general. Nor can DHS sanction families for failure to follow safe sleep practices, as all families in New York City have the right to self-determination regarding their sleep arrangements. Nevertheless, DHS will continue with this awareness campaign, as we believe the 59% decrease in infant deaths in our system in FY19 is significant and a clear indication that our efforts are moving in the right direction – at the same time, we recognize that more work needs to be done to drive this number down further. Nonetheless, DHS has updated and resent the updated materials and acknowledgement forms and directed vendors to use them.		Update and re- distribute Safe Sleep and crib acknowledgement forms.	**Completed November 2020**

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Recommendation 5: Shelter staff should ensure that they perform the required weekly unit inspections, take prompt corrective action to address the deficiencies found, and document the results in a timely manner.	Agree DHS will update our policy to include a specific timeframe in which shelters must update their records in CARES to document unit inspections. DHS policy for the time frame to document unit inspections will be updated to reflect one week from unit inspection completions.	DHS Program OPPT OPDI	Update DHS policy to include timely unit inspection updates and completion.	**December 2020**
Recommendation 6: DHS should establish and enforce timeframes for shelter providers to record the dates and results of their inspections in CARES and any successor system that may be established and in the applicable paper files.	Agree DHS distributed a standardized form for unit inspections to upload into CARES, which is a requirement. CARES is a DHS database used to document unit inspections. This documentation includes deficiencies found during the inspection, needed repairs, and work orders that address specific issues. The form has a date to record when the inspection was completed, and work orders submitted. CARES documents event dates. Case notes that are entered are time stamped. Weekly Case Record Reviews of Infants in shelter by the DHS Team is now a requirement to reinforce provider compliance.	DHS Program-FWC	See responses to Recommendations 1 & 5. Ensure provider compliance with weekly unit inspections. Conduct weekly case record reviews.	**Ongoing** **November 2020/ Ongoing**

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Recommendation 7: DHS should stress to shelter providers the significance of instructing all families with infants on safe sleep policies and providing all families with infants with safe cribs.	Partially Agree DHS agrees that this is necessary but disagrees that this is not already being done. This is currently a requirement that must be completed at intake and subsequent weekly unit inspection discussions, as reflected in the Infant Safe Sleep Advisory for parents and staff, 2018 Safe Sleep Policy, and Understanding the Monitoring Instrument. DHS has also stressed safe sleep awareness during our quarterly shelter director meetings.	DHS Program-FWC	N/A	
Recommendation 8: DHS should reinforce with shelter providers the significance of performing the required number of unit inspections in accordance with the prescribed frequency standards.	Partially Agree DHS agrees that reinforcing this requirement is necessary but does not agree that this is not already being done. DHS continues to reinforce this expectation to providers during daily calls that are led by DHS program administrators. Shelter directors attend these calls. DHS also stresses this in quarterly Shelter Director Meetings, case record reviews by Compliance Analysts, Program Administrator weekly reviews, and system wide email communications, most recently on January 27, 2020 and August 25, 2020. Program Analysts also reinforce unit	DHS Program-FWC	N/A	

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	inspections during their completion of the Bi-Annual Monitoring Instrument.			
Recommendation 9: DHS should reassess the degree to which the semiannual review adequately addresses issues of infant safety in its shelters for families with children and consider taking steps to place more emphasis on this topic and elicit additional details in its reviews and records of them. Further, DHS should reconsider the detail with which it reports the deficiencies and other issues it identifies through its reviews in its letters to providers and consider reporting them in greater detail and requiring the providers to submit CAPs in corresponding detail .	Disagree The Bi-annual Monitoring Instrument Inspection has a series of questions dedicated to infant safety, in addition to the DHS Universal Inspection Form. The Monitoring Instrument report is also shared with the provider, not just a summary letter of the bi-annual inspection. The tool reflects all findings of each hardcopy chart review and CARES review findings. Additionally, this includes case record review findings, unit inspection findings, and infant safety. DHS providers are expected to submit corrective action plans for all deficiencies identified during an inspection, not just those listed in the summary cover letter. At the completion of each Monitoring Instrument visit, an exit conference is held with the shelter director to discuss the overall case record and social services delivery findings. This includes any health and safety conditions as well as Safe Sleep. Providers know clearly each deficiency requires a corrective action plan specifically and how each deficiency was addressed. A corrective plan is put in place to ensure consistency and marked	DHS Program-FWC	N/A	

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	improvement moving forward. Provider Corrective Action Plans are not, and have not been, limited to the DHS issued CAP Letter. The Provider Corrective Action Plan addresses each deficiency cited on the DHS Monitoring Instrument.			
Recommendation 10: DHS should establish and enforce consequences for noncompliance with infant safety policies.	Partially Agree DHS agrees that strengthening enforcement is necessary but does not agree that significant compliance and enforcement efforts have not already been made. DHS established the Shelter Compliance Procedure to address on-going performance concerns, and then issued it on June 29, 2018. This procedure was shared with the auditors on September 9, 2020. Additionally, as part of the 2017 Turning the Tide plan, DHS is actively phasing out shelter providers and shelter sites that do not meet our standards, including making sure that contracts are in place for all providers who will continue to operate shelters. The auditors noted that DHS had rated five providers in this audit as performing poorly. To improve accountability of our providers, DHS is developing an elevated compliance plan for providers who	DHS Program-FWC	Establish an elevated compliance plan.	**January 2021**

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	are consistently found to perform poorly during our bi-annual monitoring activities.			