THE CITY OF NEW YORK
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

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Report on the Bureau of Day Care

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Division of Financial & Strategic Management

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Executive Summary

On August 11, 2004, an infant who was in a group family day care home in Forest Hills, Queens, died. The operator of the facility had prior substantiated complaints, and earlier on August 11, two Department of Health and Mental Hygiene (DOHMH) inspectors had visited the facility. The DOHMH Commissioner learned of the timing of the incident on Friday, September 17th and directed staff verbally on that day and in writing on Monday, September 20th, to review of the events leading up to and following the infant's death; relevant policies, procedures and regulations, and whether these were followed; day care operations generally; and to make recommendations to improve the program.

During the course of this review, team members spoke with many Bureau of Day Care (BDC) staff who have considerable expertise, experience, and a strong commitment to improving the health and safety of day care in New York City.

Background – DOHMH and Day Care

The DOHMH BDC inspects and oversees four types of day care, one regulated by the City and three regulated by the New York State Office for Children and Family Services (OCFS). These vary according to setting (e.g., residential/non-residential), numbers and ages of children allowed, and requirements for caregiver-child ratios. BDC responsibilities include authorizing and approving day care sites, certifying staff, and inspecting for licensure and in response to complaints.

Inspection Activities in this Case

On July 16th and July 29th, BDC received two separate complaints from external sources concerning two sites (one licensed, one unlicensed) operated by Heather Zlotshewer in Forest Hills, Queens.

- **On July 28th** BDC visited the unlicensed site and directed the operator to cease operating at this location, return to her licensed site and reduce the number of children in care.

- **<u>On August 6th</u>** BDC staff reportedly called the day care operator to confirm that the move back to the licensed site had occurred, and directed her to use only staff that had been properly screened and approved.

- **<u>On August 11th</u>** BDC inspectors visited both sites, confirmed that the unlicensed site was not in use, and confirmed that the other site was indeed licensed, which was the stated basis for the visit.

While BDC staff observed during their August 11th inspection that, upon their arrival, the licensed group family day care site had an insufficient number of adults present, and that certain children were out of sight of any adults, these violations were not acted on.

Case-Specific Findings

Specific to our review of the above-cited case, we have found that:

- **Inspection scope, procedures and criteria are not adequate.** The inspectors only responded to the complaint that triggered the inspection and did not address other violations that were beyond the scope of the complaint. Furthermore, the previous complaint against the provider did not elicit a sufficient response. Finally, documentation and controls for complaint inspection are limited.

- **Post-inspection follow-up is not adequate.** BCD relied on a telephone call rather than a visit to determine whether the operator had followed the directive to stop running a day care program at an unlicensed site, to return to the licensed site, and to reduce the number of children.

- **Standards and procedures for parental notification are insufficient.** There was no policy that BDC staff should notify parents of the inspectors' findings or their instructions to the provider to return to the licensed site and reduce the number of children. OCFS regulations do allow for the posting of inspection reports at a day care site, and OCFS does post limited information on its website, but detailed information regarding violations is lacking.

- **Inspectors sometime lack sufficient training, including preparation to address different types of day care.**

- **Day care oversight is subject to a complex array of State and City laws, regulations, and policies.**

- **Formal procedures for critical incident reporting and assessment are inadequate.** There was no established BDC process for reviewing the case internally to identify weaknesses or opportunities for improvement, or for reporting a major event such as a fatality to the DOHMH Commissioner in a timely manner.

Other Issues Identified

During the course of our review, other areas of concern came to light:

- **Delays in approvals and renewals of licenses and staff background checks are significant and problematic.** This often results in day care facilities operating without appropriate approvals for the operation as a whole or for particular staff.

- **Parents do not have ready access to timely reliable information about a specific day care facility's supervision requirements and child limits, or detailed information about substantiated complaints and violations.**

- **There is no unified data system for the Bureau's operational and complaint activities, and hand-held computer technology is not used in field operations.**

Recommendations

These recommendations result both from direct analysis of the case events discussed above and documents relating to BDC, and from observations by the review team during this project. Because of the limited scope of this review, many of the recommendations require further examination to determine feasibility, impact, timelines and costs.

1. Improve BDC Policies/Procedures, Operations, Training and Technology

- Develop clear, detailed written procedures for conducting inspections in response to complaints. These should include instructions to a) review key health and safety issues according to a structured, written checklist, b) determine if the operator has a history of

complaints, and c) request assistance from a supervisor if there is a question of regulation, compliance or next steps, and address the situation accordingly.

- Develop clear, detailed, written procedures and controls for complaint recording, tracking and follow-up. This should include required action steps, timelines for follow-up on compliance deficiencies, and reporting and documentation.

- Enhance training on these procedures, and train staff on the various types of day care settings, their regulatory environments, and proper inspection protocols.

- Develop clear performance indicators that accurately reflect key aspects of BDC operations, including staffing, efficiency, effectiveness and timeliness of inspections, complaint responses and follow-up actions.

- Adjust frequency of inspections using a risk-based approach when there is a greater potential for compliance deficiencies for specific day care providers that may affect the health and safety of children.

- Implement a unified information system that addresses operational and regulatory needs for all day care types. The implementation of hand-held mobile technologies during field inspections could enable real-time access to licensing, complaint, inspection and enforcement information, improving field decision-making and day care provider staff credential checks.

- Adopt a critical incident review process modeled on the clinical quality improvement approach, which would identify specific weaknesses, ensure timely and accurate reporting to executive staff (including the DOHMH Commissioner), and implement performance improvement activities.

2. Increase the Accessibility and Amount of Information to Parents and Providers

- Make information on each day care provider's licensure, required staffing ratios, limits on ages and numbers of children and detailed violation history readily available on the web for all types of day care. This information could be also be required to be posted prominently at each day care site and/or provided to parents.

Note: For State-regulated day care, the provider must post the OCFS license, which includes information on maximum capacity but is difficult to understand and provided only in English. OCFS posts information on specific providers on its website, including whether there are any current or prior serious violations.

- Improve technical assistance and information regarding health and safety standards to operators and staff.

3. Increase Interagency Coordination to Align Regulations and Improve Service

- Work with OCFS to clarify regulatory requirements concerning identification and enforcement of compliance deficiencies and address technology needs.
- Work with OCFS and the Administration for Children's Services, the Human Resources Administration, the Department of Education, the Fire Department and the Department of Buildings to streamline the approval processes, including delays in license/permit approvals and renewals and overlapping or duplicative requirements, and improve consistency in the quality of care.

Conclusion

This tragic incident has highlighted the importance of making significant improvements in existing processes and enforcement mechanisms to increase safety and health in day care settings. Although the different settings and regulatory oversights present challenges, this review identified several key areas for DOHMH to address to ensure day care quality and safety. Developing and implementing better policies, procedures, training, management oversight and information technology will improve the quality of inspections and enhance post-inspection follow-up. While these operational changes can have a significant impact, improving information access to parents and providers will empower many to be more vigilant enforcers of day care safety.

Introduction—Purpose, Scope and Methodology

On August 11, 2004, an infant in the care of a group family day care home operated by Heather Zlotshewer in Forest Hills, Queens (referenced hereafter as "HZ Day Care", alternatively known as "Devlin Day Care, LLC"), was found unresponsive and was later pronounced dead. Earlier that same day, two Health Department inspectors had visited the facility in response to concerns that the program was unlicensed. The complaint was not substantiated (the facility was properly licensed), but the inspectors failed to address several compliance deficiencies observed during their visit. In response to this incident, the DOHMH Commissioner directed the Division of Financial and Strategic Management (FSM) to conduct a review of DOHMH oversight of day care providers.

The purpose of this review is (1) to understand the specific events and DOHMH activities leading up to and following the infant's death; (2) to examine the relevant regulations, policies and procedures and determine whether they were followed concerning complaint response, investigation and resolution; and (3) to develop recommendations addressing specific weaknesses and improving general day care oversight functions. The scope of this initial review is limited by its nature as a quick-response analysis. However, the review team (including staff from FSM's Audit, Policy & Planning, and Management Information Systems [MIS] units) was able to review records and activities related to HZ Day Care and other selected materials. We identified areas for improvement and further investigation, including: DOHMH policies and procedures; staff training and supervision; information technology support systems; communication to parents and providers; and legal and regulatory provisions. Due to the limited duration of this review, some recommendations will necessarily need further refinement.

The review was conducted by analytic and audit staff through examination of operational records (manual and electronic); applicable laws, regulations, policies and procedures; existing information support systems; and fiscal and performance data for the Bureau of Day Care (BDC). The review also included interviews with BDC staff, as well as representatives from the Department's Office of the General Counsel and two other City agencies, the Administration for Children's Services (ACS) and the Human Resources Administration (HRA). In particular, we thank the staff in the Bureau of Day Care who assisted the review team during this project.

Many of these staff impressed the reviewers with their knowledge of day care and their commitment to child safety and development.

This initial review should not be viewed as a complete and thorough analysis of all aspects of BDC operations. It specifically focused on the lessons to be learned from this particular instance and other areas of possible deficiencies. Nor does this initial review constitute a formal audit under Generally Accepted Government Audit Standards (GAGAS), which would have included more extensive testing of operational data to determine the level of compliance with existing policies and procedures and the adequacy of internal controls.

This rest of this report is organized into six sections:

- Overview—DOHMH and Day Care Oversight
- HZ Day Care—Licensure and Complaint History
- HZ Day Care Case—Specific Findings
- Other Issues Identified During General Review
- Recommendations
- Conclusion

Overview—DOHMH and Day Care Oversight

Through its Bureau of Day Care (BDC), DOHMH oversees and inspects four types of day care facilities, described below:

Day Care Type	Law/Regulation	# of Children	Ages of Children	Setting
Group Day Care (GDC) (Permit)	NYC Health Code (Article 47)	7 or more	0-6 years	Non-residential
Group Family Day Care (GFDC) (License)	18 NYCRR (Part 416)	• 7 to 12 if no children under 2 years old; • 7 to 10 children if any children under 2 years old; *In certain situations 2 additional school-aged children allowed.*	6 weeks to 12 years *(under 6 weeks requires OCFS waiver)*	Home of an unrelated family
Family Day Care (FDC) (Registration)	18 NYCRR (Part 417)	• 3 to 6 if all over 2 years old; • No more than 2 children under 2 years old. • If any children under age 2, can have no more than 5 children total. *In certain situations 2 additional school-aged children allowed.*		Home of an unrelated family
School Age (SA) (Registration)	18 NYCRR (Part 414)	7 or more	5 - 15 years	Non-residential

GDC facilities are overseen exclusively at the local level in New York City. GFDC, FDC and SA facilities are all subject to State laws (New York Social Service Law, Section 390) and regulations promulgated by the New York State Office of Children and Family Services (OCFS), 18 New York Code of Rules and Regulations (NYCRR) Part 413 and others noted above. For these types of facilities, the City (through a DOHMH contract with OCFS) has a significant role in providing day-to-day oversight, including license application and renewal

processing, complaints and inspections, and recommendations for enforcement actions. However, for State-regulated day care, OCFS is the ultimate authority

BDC currently oversees a total of 12,593 facilities, of which 9,433 have received relevant official approvals (i.e., State/City licenses, permits or registrations, as required). The remaining facilities are, in general, in some stage of an approval process, or are exempt from licensure, registration and permitting requirements.

Day Care Facility Type	Facilities Licensed/Registered/Permitted	Total Facilities
GDC	1,931	2,769
GFDC	1,967	2,549
FDC	4,525	6,162
SA	1,010	1,113
All Facility Types	9,433	12,593

BDC utilizes two different kinds of staff to conduct inspections, Early Childhood Educational Consultants (ECEC) and Public Health Sanitarians (PHS). ECECs review compliance with rules regarding staffing levels and qualifications, the educational program, the health screening of staff and children, and other aspects of program operation, and provide technical assistance. PHSs review the physical attributes of the site, including such matter as square footage, sanitary facilities, storage areas, lighting, lead testing and fire and electrical safety. Additionally, field staff is organized into two main groups: those who oversee Group Day Care, and those who oversee the three State-regulated categories, including Group Family Day Care. Both PHS and ECEC positions require a bachelor's degree.

Currently, BDC is budgeted for 155 full-time positions (of which 129 are currently filled), and 26 part-time staff.[1] For FY04, the Personnel Services (PS) budget was $5.7 million, and the Other-Than-Personnel-Services (OTPS) budget was $691,000.

On September 22, 2004, in response to the events leading up to and following the death at HZ Day Care, BDC was transferred from the Division of Health Promotion and Disease

[1] Recently, candidates for 16 of the 26 positions currently vacant have been identified.

Prevention to the Division of Environmental Health, which includes most DOHMH inspection and regulatory oversight functions.

Day Care Complaints

We obtained an understanding of the complaint response and inspection process through interviews with various BDC personnel, and from written communication from the BDC Complaint Coordinator.

Most complaints are received via phone calls to BDC. Complaints are also received by mail, email, in-person/walk in, voice mail and fax. Complaints come from the general public, organizations, government agencies, community boards, parents or anonymous sources. In addition, some inspections are internally generated, based on information derived incidentally (e.g., from an information request) that raises concern about a particular day care site.

Upon receipt, complaints are assigned a severity code using an internal BDC complaint rating. If the complaint is received in the central office, it is forwarded to the complaint coordinator, the Director, or other appropriate administrator to determine the severity of the complaint and to assign the complaint to a borough office or appropriate enforcement unit. If the complaint is received in a borough office or other field office, the severity is determined by the borough manager. The complaint is faxed to the central office for tracking purposes.

An “A” complaint indicates an immediate risk or danger to children if not immediately or promptly corrected or abated. This requires a BDC inspector to visit the site and address the risks identified within 24 hours or by the end of the next working day. Examples of potential “A” complaints include fatality, serious injury or contagion resulting in medical emergency, shooting, fire, abduction, explosion, sewer back-up, collapsing structure, allegation of sexual abuse, and other situations that would present a risk of imminent harm to children. Per BDC policy, inspection reports for “A” complaints should be sent to the central office as soon as the inspection is complete.

“B” complaints might include possible unlicensed childcare, dirty facility/home, staff not fingerprinted, foul odor, children crying, pet(s) in child care area, improper menu, unsafe play area and improper lesson plan. As per a September 1, 2004, BDC memorandum, these and other

"B" complaints are to be visited no later than seven business days from the date of the complaint. Prior to this recent memorandum, the standard response time allowed by BDC for "B" complaints was reported to have been 10 business days.[2, 3]

Complaints are to be referred to either a PHS or an ECEC based on the nature of the complaint: complaints of unlicensed sites are usually referred to PHS staff. Existing written BDC procedures for either "A" or "B" complaints do not appear to directly address inadequate supervision or day care site staffing, although the BDC complaint coordinator did report that inadequate supervision could constitute an "A" complaint should the situation present imminent risk of harm to the children present.

After the complaint inspection is performed, a copy of the complaint response form is to be sent to the Central Office. If the complaint involved a State licensed facility, the results of the complaint inspection are to be entered into the State's Child Care Facility System (CCFS) and a copy of the inspection report is sent to the OCFS. Under the contract with OCFS, any required enforcement action must be formally taken by the State, not the City. After a complaint inspection has been performed, the inspector's supervisor is expected to review and sign-off on the completed inspection.[4]

Recent BDC performance indicators show that complaints increased from 869 in FY03 to 1,052 in FY04, while child abuse complaints received declined from 98 to 75. The percentage of complaints "closed" within one month during FY04 was 61%, below the 75% target and prior

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[2] State OCFS guidelines reference a 15-day response allowed for complaints other than those involving "imminent danger," so the reported BDC standard of a 10-day response standard for "B" complaints is within this requirement. The reviewers also received a 1990 BDC memorandum indicating an allowed response time for "B" complaints of five business days, however this seems to have been changed by early 2002 at the latest.

[3] The 1990 BDC memorandum references a "C" level complaint category, but this appears to be no longer in use.

[4] In its "Complaints" section, the OCFS *Child Day Care Licensing Staff Training Manual* lists two main complaint types, "imminent danger" (defined as circumstances that without some level of intervention a child will almost certainly be seriously injured or killed in the next 24 hours), and "all other alleged violations." In an appendix, the OCFS manual also lists criteria for a "Serious Violation", which includes leaving children alone and other forms of inadequate supervision, and does not direct the inspector how to proceed in such a situation. It is important to note that these classifications are denoted in the OCFS training manual, however, they do not explicitly match the complaint classifications currently used by BDC that appear to predate the OCFS guidelines. Moreover, 18 NYCRR Section 413.3(f), Enforcement of Regulations, cites "inadequate or incompetent supervision" as potentially a Class I violation (harming a child or placing a child at risk of death, serious disfigurement, or impairment, subject to fines up to $500 per day) or a Class II violation (places a child at risk of physical, mental or emotional harm including, subject to fines up to $200 per day). The definition of Class I violations in this section is thus quite similar to the definition of "imminent danger" in the OCFS training manual; however it is restricted to basis for imposition of fines, rather than level of complaint response.

year actual rate of 68%. In this instance, “closed” is defined as either determination that the compliance issue identified has been substantiated and remediated, or that the complaint was investigated and not substantiated. The rate of complaints closed within one month declined dramatically towards the end of FY04, and the cause of this decline is still under review.

Staffing Ratios in Day Care Facilities

For each type of day care, including Group Day Care and Group Family Day Care, there are different rules mandating the required number of adults in relation to the number and ages of children present.

Mandated Group Day Care staffing levels vary based on the age and number of children. A qualified teacher for each group of children must be present at all times, and the allowable number of children in each group depends on their respective ages: as children’s ages increase, the allowable number of children increases as well, eventually requiring an assistant teacher per City regulations. For example, in Group Day Care, a teacher cannot care for more than eight children who are less than a year old, and must have an assistant teacher present for any group including more than four children under the age of one.

State OCFS regulations for licensed GFDC sites differ substantially from the City’s regulations for Group Day Care facilities. Under OCFS regulations, a licensed operator, assistant or alternate assistant alone may care for a maximum of six children; if there are more than six children present, then both the provider and an assistant or an alternate assistant must be present. Generally, a maximum of 12 children is allowed, or 10 if there are any children under 2 years old present; in certain situations (before or after normal school hours, or when schools are not in session), up to two additional school-age children may be present. Assistants and alternate assistants must be listed on the GFDC license application, in addition to the operator. There may be no more than four children under the age of two present,[5] and for every two children under age two there must be one adult caregiver.

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[5] Per August 25, 1995 memorandum issued by New York State Department of Social Services (predecessor of OCFS), *Child Day Care Enforcement Policy and Procedures*.

Information Technology

CCFS, a State-developed computer system used by BDC for child care management that allows for information sharing between DOHMH and OCFS, has been implemented over the past several years. CCFS is deployed state-wide, and jurisdictions are mandated to use the system to report and track registration and licensing, inspection, complaint, and enforcement information for State-regulated (FDC, GFDC, and SA) day care facilities. The ability to create reports is limited to pre-defined reports established within the system, and there does not currently appear to be data export or integration capability that would enable BDC to share data with CCFS from external systems.

CCFS is not designed to track these activities for City-permitted GDC facilities. BDC reports having had discussions and an agreement with OCFS to include the functionality necessary to support GDC sites; however, OCFS is reported to have agreed to incorporate City-specific GDC site functions only after completing development of functionality related to State-regulated facilities. At the present time, it is reported that for GDC sites CCFS functions for registration/licensing, inspections and complaints are fully operational, but functionality related to enforcement actions has not been completed.

As a result, City-regulated GDC facilities have not yet been included within CCFS, except for receipt and tracking of GDC complaints.[6] This functionality is not being used, apparently because the CCFS system cannot currently capture information on what is done in response to GDC complaints. For GDC facilities, there is limited automation using a stand-alone Microsoft-ACCESS database, which operates on a single PC in the central office. Thus, at this point there is no integrated day care data support system that provides all BDC staff with information on all types of day care overseen by DOHMH.

CCFS is built using client/server technology, with a PowerBuilder application interface and an Oracle database. OCFS designed and installed this application for use by BDC, including PC workstations, peripheral equipment, local connections and connectivity to a State-run

[6] A CCFS module for GDC-type facilities has been developed for use elsewhere in the State, however it does not support the laws and procedures relevant for overseeing GDC facilities in the City.

network and the CCFS system. BDC offices that are responsible for State-regulated facilities are connected to the State-run network described above through 384Kbps data circuits.

This network and the PC workstations connected to the network are completely detached and separate from the DOHMH network, and are managed completely by OCFS through a CCFS liaison and technical contact, who is a BDC employee. The CCFS technical liaison can create, modify and delete accounts, as well as assign roles and access rights to individuals.

Through an interview with the BDC technical liaison to CCFS, it was reported that the system is generally reliable, with little downtime although response time is somewhat slow. However, application performance issues were reported to occasionally occur, with the lack of adequate bandwidth for connectivity described as the cause. There are currently 149 CCFS user accounts issued, with approximately 130 accounts in use during a typical day. However, only a limited number of BDC staff are equipped with second PCs connected to the DOHMH network. It is our understanding that it is technically feasible to access CCFS via PCs on the DOHMH network, but this capability has not been enabled to this point by OCFS, creating an additional barrier to BDC staff being able to easily access information on all types of day care through a single system.

HZ Day Care—Licensure and Complaint History

Heather Zlotshewer was officially registered as a Family Day Care provider at 109-05 72nd Avenue, Forest Hills (Queens), NY on June 9, 1999. This registration was then renewed on July 25, 2000. She first received a license to operate a GFDC site at the same location on September 6, 2001. On June 19, 2003, she received a new GFDC license for 109-19 72nd Avenue, also in Forest Hills, for which much of the background and screening information was carried over from her prior license. As part of the application for her new GFDC license, a separate inspection was performed for the 109-19 72nd Avenue site on January 30, 2003.

The events leading up to the death of an infant being cared for at the 109-19 72nd Avenue GFDC site, including two external complaints, three internally-generated inspection orders, and five on-site inspection visits, are as follows (all dates 2004, all addresses in Forest Hills):

- **On July 16** the BDC Central Office received a complaint (documented on complaint form #15822) that an unlicensed day care facility was being operated at 110-06 72nd Avenue, Forest Hills; that the facility had no bathroom or kitchen; and that the operator was licensed to provide child care, but at a different location. This complaint was rated as level "B" under BDC's complaint rating system.

- **On July 23** the BDC Queens borough manager received a telephone call requesting information on the day care facility at 109-19 72nd Avenue, but was unable to identify this site on a listing of GDC facilities, or in the CCFS listing of State-regulated facilities (GFDC, FDC and SA). It is not clear why this search failed;[7] however, the borough manager ordered an inspection (priority "B") to check for a possibly unlicensed site.[8]

- **On July 28** an inspection conducted in response to the July 16th complaint verified that the operator was not licensed at the location in question (110-06 72nd Avenue). The operator stated that she was licensed for group family day care at 109-19 72nd Avenue, but that location was being painted and therefore she had relocated temporarily to the unlicensed site. Although there is no written record of this, the inspector reported that on

[7] Subsequently, members of the review team were able to locate records for this facility in CCFS.
[8] The July 23rd inspection order was recorded on complaint form #12728.

July 28th she also went to 109-19 72 Avenue to: 1) determine whether the operator was operating at both locations; 2) to verify the operator's claim that the facility was being painted; and 3) to evaluate whether the return to the licensed center was feasible for the next day. She confirmed that the operator was not operating two centers; that the licensed facility had been recently painted; and resolved with the operator that the program would cease operations at the unlicensed site and return to the licensed site.

The inspector also reported that the operator was caring for 16 children (seven of whom were under two years of age) at the unlicensed site, in excess of the number allowed for a group family day care program, and only three adults were present to supervise the children.

The inspector indicated in the inspection response that, (1) the child care program was being operated without a license at this site; (2) the program had to relocate back to the licensed child care site (109-19 72nd Avenue); and (3) the provider must operate within the capacity of her GFDC license (a maximum of 12 children and one adult for every 2 children under the age of 2, as clearly stated on the license), and instructed the operator to correct these deficiencies. The inspector did not indicate that the operator presented any documentation confirming that the two assistants present had been properly screened and officially approved. The fact that the two assistants were not properly authorized was discovered subsequent to the field inspection of July 28th.

- **<u>On July 29</u>** the BDC Central Office received a complaint that the provider at 109-19 72nd Avenue facility is always at 110-06 72nd Avenue and employs unscreened staff. This complaint was assigned #15822B (linking to complaint #15822of July 28th for 110-06 72nd Avenue), rated level "B", and assigned for follow-up with instructions that both locations be visited at the same time. The July 28th inspection had already substantiated this complaint, though, and no field visit was performed related to #15822B.

- **<u>On August 6</u>** the BDC Queens borough manager ordered an inspection (priority "B") after the office had received a set of facility plans for a Group Day Care center at 110-06

72nd Avenue, on the basis that it is unusual to receive plans for review without prior discussion and attendance at a training session by the operator.[9]

- **<u>Also on or about August 6</u>** in connection with Complaint #15822B, the operator of HZ Day Care was reportedly contacted by telephone to verify that she had returned to the 109-19 72nd Avenue licensed GFDC facility, and was advised to only use assistants who had been properly screened. No follow-up field visit was made to confirm the return to 109-19 72nd Avenue or compliance with staffing requirements.

- **<u>On August 11</u>** in response to the inspection order of July 23rd, two BDC inspectors visited the 110-06 72nd Avenue and 109-19 72nd Avenue sites. They confirmed that the unlicensed 110-06 72nd Avenue site was not in operation and that the 109-19 72nd Avenue was a licensed GFDC facility. However, the inspection did not address critical problems at 109-19 72nd Avenue regarding staffing levels and the location of children out of the line of sight of any adults. It was subsequently on this day, after the inspection visit, that an infant at this location was reportedly found unresponsive in a crib on the second floor of the 109-19 72nd Avenue group family day care site, and was later pronounced dead.

- **<u>On August 12</u>** BDC management was separately notified by the New York Police Department, the OCFS Director for Early Childhood Services, and the New York State Office of Child Investigation (OCI) that a child at the 109-19 72nd Avenue group family day care site had died. OCFS issued a "Cease and Desist" letter that was mailed to Ms. Zlotshewer, suspending and revoking her license. BDC staff attempted to serve this letter to Ms. Zlotshewer in person, but were unable to do so. Also on this day, BDC staff who conducted the inspection of HZ Day Care at 109-19 72nd Avenue were instructed by BDC management to document in writing all details of their August 11th visit to this location.

  The BDC inspectors reported that they arrived at approximately 2:15PM; that the operator was alone when they arrived; that the operator made a telephone call, and

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[9] The August 6th order for an inspection of 110-06 72nd Avenue was recorded on complaint form #12730. This form was completed as if an external, anonymous complaint had been received by telephone; however, the Queens borough manager confirmed orally to members of the review team that in fact the inspection had been ordered and the form completed based on the receipt of facility plans for this address. The review team has received documentation indicating that a preliminary site inspection for the proposed GDC facility was conducted on April 13, 2004, and that the plans identified by the Queens borough manager were received on June 29, 2004.

shortly afterward a second woman arrived to assist her; that they heard noises upstairs, but were told by the operator that it was her son and his friend playing there; that they asked the operator two separate times to check upstairs, which she did on both occasions; and that they departed 15 to 20 minutes after arriving. The inspectors did not go upstairs to investigate first-hand the noises they heard, or direct the operator to bring the children on the upper floor downstairs so that they would be in direct line of sight for the operator and/or her assistant(s).

- **On August 13** As a result of the infant death at 109-19 72nd Avenue GFDC site, the BDC Central Office instructed inspection teams to visit both sites (109-19 72nd Avenue and 110-06 72nd Avenue) as a priority "A" matter. Inspection visits were completed and confirmed the closure of both sites.[10]

- **On August 16** a meeting and interview with the operator of HZ Day Care took place at 432 Union Street in Brooklyn (a restaurant), at which point the "Cease and Desist" letter prepared by OCFS was personally served by the BDC Enforcement Unit. On this day as well inspection visits were also made to both sites by BDC staff to confirm their closure.

- **On August 18** the BDC Enforcement Unit visited both 109-19 72nd Avenue and 110-06 72nd Avenue and again confirmed that day care services had ceased at each address.

[10] The August 13th directive was recorded on complaint form #15949.

Address	Complaints & Inspection Orders	07/16/04	07/23/04	07/28/04	07/29/04	08/06/04	08/11/04	08/12/04	08/13/04	08/16/04	08/18/04
110-06			8 business days		6 business days						
	#15822: Illegal day care facility at 110-06 **#15822B:** Provider at 109-19 is always at 110-06 site and employs unscreened staff	Complaint 15822 filed		15822 Response: Visit verified 110-06 as illegal; operator directed to return to 109-19 and reduce # of children	Complaint 15822B filed	15822B Response: Phone call to operator to confirm move to 109-19					
	#12730: Office received plans for 110-06 , which was unusual without prior knowledge					Inspection Order 12730 filed	Visit. Confirmed shut-down of operations at 110-06				
109-19	**#12728:** Phone inquiry sparks inspection order indicating possible unlicensed site		Inspection Order 12728 filed				Visit. Verified 109-19 was licensed				
					13 business days						
	#15949: directs inspectors to visit both sites and serve operator with "cease and desist" letter							BDC notified of child's death; letter prepared by State to suspend and revoke license of HZ.	Inspection Order 15949 filed; site visits to both locations confirm not in operation	Meeting with HZ Day Care operator; BDC served "cease and desist" letter; site visits to both locations again confirm not in operation	BDC visit to both sites at 109-19 and 110-06; Confirmed that day care facility operations ceased at each address

HZ Day Care—Case-Specific Findings

Our review of HZ Day Care included operational and administrative records; State and City laws, regulations, policies, procedures and training materials; and interviews with BDC staff. While we identified certain lapses in compliance with existing protocols, the inadequacy of those protocols and issues of training and follow-up are significant as well. What also emerges is that BDC staff may not have linked together a series of deficiencies identified for HZ Day Care, perhaps affecting the level of intervention with this provider.

Specifically related to our review of HZ Day Care, we found the following:

1. Inspection Scope, Procedures and Criteria Need Improvement

We were unable to obtain an explicit statement of what is expected during a complaint inspection. The intention of the program is clear: the inspector should evaluate the complaint and address any imminent dangers that are apparent at the time of the inspection. An appendix to the OCFS training manual references “lack of supervision or inadequate supervision” as a “serious” violation, but does not directly state that this constitutes “imminent danger.” Furthermore, 18 NYCRR Part 413.3(f) lists “inadequate or incompetent supervision” as a possible basis for either a Class I or Class II violation for purposes imposition of fines, of which the criteria for Class I are quite similar to those of “imminent danger”. However, nothing about the complaint process gives any indication of what this means in practice. There is no minimum amount of information to be documented as part of a complaint inspection. There are no standard questions about the general adequacy of the sanitary or staffing arrangements. There is no inspection checklist, and no explicit protocols for inspection or follow-up. The inspection reporting form contains only an open field for the inspector to report on the circumstances observed upon arrival and investigation.

The inspection of 109-19 72nd Avenue on August 11th was conducted in response to concerns of an unlicensed day care facility operating at this address. The inspectors verified that the site had a valid license, and one inspector reported “8 babies + 2 [children] upstairs” present. The inspectors concluded that the complaint was unsubstantiated, and terminated the inspection.

The inspectors did not record two serious regulatory violations they observed: that the provider was alone with at least ten children, and that there were children upstairs who were not being supervised. (They have reported that they saw eight children, heard at least one child upstairs, and were told by the provider that her own child was playing with a friend in a private area.) In a Group Family Day Care site, an operator is required to have an assistant present to care for the eight children in view and to have one caregiver for every two children under age two, and the entire residence is subject to inspection.

Had the inspectors been following a protocol that assured a review of the most important risks to child health and safety, it is more likely that they would have acted on the potentially dangerous conditions they observed during the inspection. Moreover, there is a lack of clarity as to the actions that should be taken when potentially dangerous situations are identified. Had adequate policies and procedures for addressing such situations been in place, and BDC staff fully trained on such procedures, the August 11th inspection at 109-19 72nd Avenue may have resulted in a more forceful and immediate intervention.

2. Post-Inspection Follow-Up Actions Were Not Adequate and Need To Be Reinforced

The July 28th field inspection indicated that the operator was illegally running day care services at 110-06 72nd Avenue with substantially inadequate staffing considering the number and ages of children present. The names of the assistants were gathered, and it was determined subsequently that they had not been properly screened and approved. (As listed above, a second complaint, #15288B, specifically alleging unscreened staff was received as well.)

The BDC inspector ordered the operator to return to the licensed facility at 109-19 72nd Avenue. BDC staff called the operator a week later to verify compliance, but no field inspection was performed until August 11th. We were advised by some BDC staff that a follow-up inspection on July 29th would have been appropriate, since even without a full inspection, on July 28th the operator was found to be in violation in three significant areas: the use of an unapproved facility, inadequate staffing levels, and the use of unscreened staff. Furthermore, the provider was directed to return to the 109-19 72nd Avenue site and immediately reduce the number of children served to the level permitted by her GFDC license. We were not provided any written

guidelines for supervisors or field inspection staff concerning follow-up inspections, though, raising questions as to whether this procedure has been fully established within BDC.

It is relevant that the "Roles and Responsibilities" section of contract between OCFS and DOHMH states that all violations must be followed to correction. If not corrected, referral shall be made to OCFS for enforcement action as required by statute and regulation. Furthermore, the "Enforcement" chapter of the OCFS training manual mentions that in case of an unlicensed operation, the OCFS Bureau of Early Childhood (BECS) must be informed so that a "Cease and Desist" letter (which contains an order to cease operation, and advises on possibility of fines up to $500 and applicable hearing rights) can be issued.

However, since DOHMH is a contractor to OCFS, and cannot issue official Notices of Violations (NOVs) or "Cease and Desist" letters, in the absence of such an action by OCFS there may not be sufficient authority to immediately intervene, and the OCFS training manual alone does not provide adequate guidance to BDC inspectors in this regard. Nor does the OCFS training manual specify when verification of compliance with a "Notice of Violation" must be completed. It does specify minimum frequencies and durations for follow-up inspections, and if non-compliance persists, OCFS is to draft a Statement of Charges (SOC).

In the case of HZ Day Care, it does not appear that BDC completed the post-inspection actions needed to ensure compliance with the corrective actions required of the operator, including the order to "Cease and Desist" operations at 110-06 72nd Avenue. Moreover, there do not appear to be clearly established BDC guidelines and procedures for post-inspection follow-up actions and required timeframes in cases where deficiencies have been identified.

3. Standards and Procedures for Parental Notification Are Insufficient

On July 28th the inspector who visited the unlicensed facility at 110-06 72nd Avenue directed the operator to return to her licensed site at 109-19 72nd Avenue and reduce the children served to the limit for a group family day care license (a maximum of 12 children, or 10 children if any under 2 years old, plus up to 2 additional school-age children in limited situations). This inspection result raised two issues regarding parental notification: documented compliance deficiencies and the need for several children to be placed in other day care arrangements.

Per State regulations, circumstances and situations that address parental consultation or notification include:

- **Unlicensed facility.** Section 390 of the Social Services Law states that in case of an unlicensed facility, the operator has to be informed in writing by OCFS of the licensing violation and the provider has to notify the parents or guardians of children in care of the licensor violation.

- **Over-capacity and inadequate supervision.** The OCFS Training Manual advises pre-planning the inspection based on type of complaint noted at complaint intake. If extreme over-capacity and little or no supervision is part of the complaint, the inspector may need to notify parents and providers of program closure.

- **Sleeping and napping arrangements.** Per 18 NYCRR Section 416.8, arrangements are to be made between provider and parents, on supervision during sleeping and napping, area of nap and bed, playpen or a crib. Caregivers must always be present on the same floor as napping and awake children, and all interior doors must be open.

- **Caregiver substitutes.** Per 18 NYCRR Section 416.8(c), in the case of short-term non-reoccurring absence of the provider and the assistant, a substitute or an alternate assistant may care for the children, but parents must be notified of the substitution. If no substitute or alternate assistant is available to care for the children, parents must be notified that care will not be available for that day. Alternate assistants and substitutes are required to have varying levels of State screening and approval. Only in an emergency situation may children be left with only substitute day care staff on-site.

Since all of the above circumstances appeared to have occurred in connection to HZ Day Care, the issue of parental notification is of direct concern. Apparently, at no point did BDC notify parents, or require the provider to notify parents, regarding any of the above-listed issues. While the regulatory mandate for BDC to do so is somewhat ambiguous, relying on day care operators to notify parents of compliance deficiencies is inadequate and reduces the likelihood that parents will be sufficiently informed of conditions that might affect their children's health and safety or their choice of day care providers.

4. Training and Unfamiliar-Situations Procedures Are Insufficient

The BDC inspectors who visited 109-19 72nd Avenue on August 11th did not address compliance deficiencies with respect to enforce the appropriate GFDC regulations for this site. This raises two distinct concerns:

- **The breadth of training for inspectors on regulations and compliance requirements for different types of day care facilities is limited.** The August 11th inspection at 109-19 72nd Avenue, a GFDC facility, was conducted by BDC PHS staff who were more familiar with GDC facilities. Interviews with BDC supervisory staff indicate that inspectors frequently specialize in particular types of facilities. PHS and ECEC staff focus on different issues, and therefore are less familiar with the different rules and regulations for various types of facilities and conditions. This creates challenges and increases the potential for possible violations to be overlooked. Furthermore, it limits the flexibility of BDC to respond quickly and effectively to complaints and thus may reduce the efficiency and effectiveness of staff utilization.

- **Procedures for dealing with unfamiliar or unexpected situations are not adequate.** Contacting a supervisor or other BDC staff person for further instructions is reportedly a fairly common occurrence. That neither PHS inspecting the sites in question felt compelled to do so under these circumstances may have had significant consequences. It would have been appropriate to call for instruction on handling seemingly inadequate supervision. The State OCFS training manual makes clear that an inspector responding to complaints is to refer to OCFS regulations and their supervisor for specific procedures to follow. However, it should be noted again that the BDC staff who visited 109-19 72nd Avenue on August 11th do not ordinarily inspect State-regulated GFDC sites, raising the question of whether BDC has provided field staff with sufficient procedures, training and equipment (such as cellular phones or two-way radios) to contact a supervisor or other BDC official when confronted with unfamiliar or unexpected situations.

5. Day Care Oversight Is Subject to a Complex Array of State and City Laws, Regulations and Policies

Several legal interpretation issues emerged in our review of HZ Day Care, including, "If a licensed GFDC operator opens an unlicensed facility, should BDC follow State or City regulations in addressing the situation?" The day care services she provided at 110-06 72nd Avenue before being instructed to return to her licensed location at 109-19 72nd Avenue would seem to represent both (a) a State violation of her GFDC license, since 110-06 72nd Avenue was not her approved GFDC location, nor was it a "residence" or "family home", and (b) a City violation of operating an unlicensed GDC facility, under NYC Health Code Article 47.

Other key differences between State and City regulations are evident as well, such as the classification systems for complaints and required staffing levels and qualifications for day care providers. All of these issues create challenges in responding to complaints and conducting inspections.

6. Documentation and Controls for Complaint Inspection and Follow-Up Are Limited

Based on a very limited review of CCFS with regard HZ Day Care, it appears that information currently being entered may not be adequate for the oversight of complaint handling. CCFS indicates when inspections took place, whether complaints were substantiated, and any formal enforcement actions that occurred. It can be used to monitor timeliness of response. However, there may not be sufficient detail on inspection results and subsequent actions to determine whether the response was appropriate, nor do BDC staff have access to sufficient reports on the status of complaints.

The complaint documentation that we received for these and other complaints ends with the complaint response, which includes the findings of the inspector, the directives given by the inspector to the provider, and a checklist field called "notice required" with the following choices: unsubstantiated, substantiated and corrected, corrective action needed, fines, denial of

renewal, suspension, revocation, other. There is also room for a compliance date and for supervisory signature,[11] but no space for supervisory comments or planned follow-up actions.

Unless detailed information is provided about findings and planned actions, no individual other than the supervisor of the inspector is in a position to review or advise on the timeliness and appropriateness of further intervention. This may be appropriate for some complaints, and for the results of routine inspections, but is inadequate for central monitoring of priority complaints and for other complaints with serious implications.

A related review of all seven "A" complaints and other orders for site investigations by BDC during August, 2004 (including the actions of August 13th recorded on complaint form #15949, referenced above), is consistent with our observations from reviewing the HZ Day Care case. Our review of these complaints disclosed that BDC inspectors do not always record the age of the children being supervised, so that the adequacy of facility staffing at the time of an inspection cannot be easily determined. There also is generally no indication on complaint response forms that staff on-site at the time of a particular inspection have been properly approved to provide day care services.

A New York State Comptroller's audit of Day Care (February 25, 2002) recommended that DOHMH "develop a complaint processing and accountability system capable of filing and categorizing all complaints, tracking the status of complaints to ensure that they are investigated within the required time frames, monitoring actions taken to resolve the issues raised, and facilitating reporting of results." An update to this audit (January 9, 2004) indicated that this was implemented, based on an inspection of the complaint system component of CCFS. However, this case has revealed that the implementation of CCFS alone is not sufficient to ensure proper complaint documentation, follow-up and monitoring, especially in the absence of clearly-defined management oversight and controls. Thus, while CCFS has been implemented, it appears that not all important needs for complaint processing and accountability have been achieved.

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[11] None of the complaint forms related to HZ Day Care (including both external complaints and internally-generated inspection orders) that the review team examined were signed by a BDC supervisor, an apparent lapse with respect to expected operating procedures.

We have been advised that the BDC Complaint Coordinator receives copies of the inspection reports, but that further inspection, compliance or enforcement activities are not within this position's scope of responsibilities. This is consistent with representations made to the State Comptroller auditors, who were told that it would not be appropriate for the BDC Complaint Coordinator to review post-inspection follow-up actions and documentation, since BDC and OCFS management would review information entered into CCFS to ensure that follow-up was appropriate and properly documented.

7. Formal Procedures for Major Incident Reporting and Assessment Are Lacking

There does not appear to have been any automatic review of the events leading up to and following the death of the infant on August 11th. There also was no clear process for reporting this incident to the DOHMH Commissioner, who first learned of both the infant's death and of the same-day inspection more than a month later.

The "Death of a Child in Child Care" chapter of the OCFS training manual covers required follow-up steps, including: (a) reports to complete and maintain; (b) actions to take by the licensor, and (c) investigative questions to be asked about the incident. As the designated Regional Office, DOHMH must investigate every death in child care to determine whether regulatory violations occurred and whether other children can safely remain in care at the facility in question. OCFS may collaborate with other agencies for a more extensive investigation and to address all inquiries. The OCFS manual does not note in this chapter the need to inform all parents of children attending the day care facility where the incident occurred; however, State Code 416.15(a)(14), "Management and Administration" notes that the caregiver must immediately notify OCFS of fatalities and serious injuries.

While OCFS regulations and guidelines are fairly detailed, our review did not identify any established procedures for a formal BDC examination of major incidents (such as fatalities), or a process for timely reporting of such incidents, with regard to how BDC staff had performed their functions, whether process and policy improvements are warranted, and who must be alerted in such a situation.

Other Issues Identified During the Review

In addition to specific findings related to HZ Day Care, during our fieldwork and analysis, we have identified additional areas of concern that should be addressed, or examined in greater detail, to determine an appropriate course of action. Many issues covered in this section have been highlighted by other City agencies with involvement in day care services, as well as advocacy organizations, OCFS and external auditors.

- **Delays in license/permit approvals and renewals, and in completing staff screenings are significant and problematic**. This concern has been highlighted by providers, advocates, other City agencies, OCFS and external auditors, from both operational and legal perspectives. OCFS has communicated to DOHMH that the City lags behind the rest of the state in timeliness of required background and criminal record checks for day care provider staff; this is a key issue given high levels of day care provider staff turnover. Any delays in DOHMH site inspections or incomplete provider applications or renewal documentation can also delay new facilities from opening and increase the time existing facilities operate without all required authorizations and approvals in effect.

  Advocacy groups also have reported that background checks, finger-print processing and perhaps certain other documentation may be duplicated by different government agencies, resulting in multiple submissions by providers. Whether this observation is accurate, and, if so, whether it can be resolved by process improvements or would require changes in laws and/or regulations requires further investigation.

- **Parents do not have ready access to timely reliable information about a specific day care facility's supervision requirements and child limits, or information about substantiated complaints and violations.** City permits and State licenses/registrations are required to be posted, and provider-specific information (including whether there are current or previous violations but not the details of the violation) is available on the OCFS website, but there is no central repository that covers all types of day care overseen by DOHMH.

- **Inspection cycles for certain types of day care facilities and/or certain providers may not be adequate to reasonably address health and safety risks.** This is of particular concern for facility types and providers at higher risk for health and safety risks.

- **There is no unified data system that supports the full range of BDC operations, and no mobile information technology support available to inspection staff during field visits to day care facilities for complaint investigations.**

- **The complex legal environment creates challenges.** Parents are likely not aware of health and safety standards, required staffing levels qualifications, and BDC's role in regulatory enforcement. Some providers may require more technical assistance.

- **BDC staffing vacancies have limited timely and effective complaint response and follow-up, and may have also affected timeliness of day care application review and renewal processing.**

Recommendations

These recommendations result both from direct analysis of the HZ Day Care case review and from the general observations of the review team during this project. Because of the limited scope of this review, many recommendations will benefit from further examination to determine feasibility, timelines and costs.

Recommendation #1: Develop clear, detailed written procedures and protocols that support effective oversight of all types of regulated day care facilities, and thoroughly train BDC inspection staff on these procedures. These procedures and protocols should address issues such as complaint categorization, observed levels of health and safety risks, and follow-up actions such as compliance enforcement, parental notification, supervisory contact, etc. They should provide BDC staff with a unified set of guidelines that cover both State and City regulations and policies as relate to different day care categories. Training BDC on these procedures will also increase flexibility of staff assignments and staff preparation for appropriately responding to unfamiliar or unexpected situations.

Recommendation #2: Improve information access by parents and the public. Parents should be recognized as an integral part of the overall day care oversight and improvement process. Parents are the best day-to-day eyes and ears into day care program operations, and need to have detailed information readily available about day care standards and options in general and individual providers specifically. This should include ready availability of appropriate provider-specific application and renewal information; approved staff and adult/child ratios; child capacity; documented compliance deficiencies and violations; and instructions for submitting complaints and monitoring BDC and provider responses. As soon as practicable, this information should also be made available on the internet, by phone and fax, and possibly be required to be posted prominently on-site at each day care facility or given to each parent upon child enrollment. DOHMH also should consider whether there are effective means of gathering information from parents such as through surveys, interviews, or suggestion response forms.

<u>Recommendation #3:</u> **Identify and address primary reasons for delays in regulatory approvals and renewals, including day care staff screenings, so services can come on-line more quickly with necessary authorizations in place.** This should include examination of the finger-print process to reduce required completion time and avoid potential duplication of effort in meeting differing State and City agency requirements, and child abuse registry clearances as well. A universal day care "authorized staff identification card" may help inspectors make a timely and accurate determination whether staffing levels and qualifications meet requirements. Timely day care provider staff approvals are also important in light of the high rate of provider staff turnover and the need for providers to maintain adequate staffing.

<u>Recommendation #4:</u> **Strengthen BDC tools and controls for complaint recording, tracking and follow-up to ensure proper response and action by both BDC staff and day care operators.** This is essential for improving line staff performance, managerial oversight, supervisory review, and Bureau accountability. A checklist that includes core issues to be reviewed during any complaint inspection should be implemented. This would enable inspectors to more easily identify conditions that need further review and/or specific next steps and follow-up actions, including increasing staffing levels, reducing the number of children served, and mitigating other health and safety risks. Tools and controls should also be implemented that enforce timely complaint assignment, investigation and follow-up by BDC staff in correcting compliance deficiencies and verifying actions taken.

<u>Recommendation #5:</u> **Improve information dissemination and technical assistance on day care regulations and compliance standards to program operators and staff.** This information should include health and safety standards and licensure and operating requirement, so that providers and staff are better equipped provide safe day care and operate within the required regulations.

<u>Recommendation #6:</u> **Adopt a critical incident-review process, modeled on the clinical quality improvement approach.** This would entail using clearly-defined criteria to identify what is a critical incident, the reporting of the incident to a specified group of executive staff including the Commissioner, analysis of any weaknesses that lead to the incident, and implementation of performance improvement activities.

<u>Recommendation #7:</u> **The DOHMH Office of the General Counsel should assist BDC and the Bureau of Policy, Planning, Quality and Development (PPQD) in working with OCFS to address legal interpretation issues and develop options for streamlining and harmonizing State and City regulations.** Defining and promoting alignment of State and City legal and regulatory requirements would benefit BDC staff, day care providers and parents of children needing day care alike. This is necessary to inform training curricula and develop policies and procedures that increase compliance with legal requirements.

<u>Recommendation #8:</u> **BDC staffing, including positions, skills and training, should be carefully reviewed as new approval, inspection, and complaint handling procedures are adopted.** Staff roles should be examined, as well as the titles/levels of certain positions. In the short term, filling vacant positions should be given high priority. National best-practices should be identified for possible application at the State and local levels, in particular regarding staff skills and levels. This should also include ensuring that DOHMH has the necessary authority to take action immediately when situations involving imminent danger are observed.

<u>Recommendation #9:</u> **Coordinate with other government agencies involved in day care to avoid excessive disruption to existing services that would reduce access or availability.** OCFS is a critical partner, as are HRA, ACS and the City's Department of Education, since they play critical roles in the child care funding and delivery system. The Fire Department and the Department of Buildings are also important partners due to their roles regulating facilities.

<u>Recommendation #10:</u> **A risk-based approach to planned inspections (other than those required for license/permit issuance and renewal) should be considered, based on prior compliance issues for particular day care programs and on program characteristics historically associated with compliance deficiencies.** This should include a minimum standard for inspection cycles, with more frequent and/or detailed inspections for higher-risk providers. DOHMH should consider not accepting the contract to regulate these facilities unless sufficient resources for inspections are provided.

<u>Recommendation #11:</u> **Implement an information system that addresses all the operational and regulatory needs for all day care types, and utilize mobile computers which assist and direct inspectors conducting inspections and provide information on regulations and day**

care site history and licensure. The current version of CCFS is not capable of supporting the full range of BDC functions and responsibilities. BDC should utilize another system that can interface with CCFS in order to meet state needs, but also can and also meet all the Bureau's needs. This could be done by enhancing current DOHMH inspection systems if possible, or by developing or purchasing a new system. We will need OCFS to partner in this effort if DOHMH is to continue oversight of State-regulated day care providers.

BDC also should implement mobile technology, as is used in some other inspection programs. Using mobile technologies during field inspection could enable real-time access to licensing, complaint, inspection and enforcement information, which would improve field decision-making. The latest information collected and known to BDC—including licensure, violations, and regulations—can be directly shared with the field inspector. This would also facilitate operator and staff credential checking. The use of mobile technologies could standardize the inspection process, by following a procedural script and mandating field inspection activities based on established procedures. Enforcement actions could be determined based on a rules-based engine that standardizes and improves corrective actions.

Recommendation #12: Develop BDC management indicators that accurately reflect key performance objectives, risks, and areas for improvement. A revised set of periodic indicators would help ensure that both BDC management and senior Agency officials are able to stay abreast of progress towards achieving desired program outcomes, as well as identifying aspects needing further attention and resources.

Conclusion

This tragic incident has highlighted the importance of making significant improvements in systems that promote safe and healthy day care settings. Although the different settings and regulatory oversights present challenges, this review identified several key areas for DOHMH to address. Developing and implementing better policies, procedures, training, oversight and technology will improve the quality of inspections and enhance follow up. In addition to making these operational changes, improving information flow to parents and providers will empower many to be vigilant supporters and enforcers of day care safety.