ADMINISTRATION FOR CHILDREN & FAMILIES
Office of Head Start | 4th Floor – Switzer Memorial Building, 330 C Street SW, Washington DC 20024 eclkc.ohs.acf.hhs.gov

Program Performance Summary Report

To: Authorizing Official/Board Chairperson
Hon. Michael Hancock
City and County of Denver
201 W Colfax Ave
Dept 1101
Denver, CO 80202 - 5332

From: Responsible HHS Official

Date: 03/23/2023
Tala Hooban
Deputy Director, Office of Head Start
On behalf of Mr. Khari M. Garvin
Director, Office of Head Start

From July 18, 2022 to September 23, 2022, the Administration for Children and Families (ACF) conducted a monitoring review of City and County of Denver Head Start and Early Head Start programs. We wish to thank the governing body, policy council, staff, and parents of your program for their cooperation and assistance during the review. This monitoring report has been issued to Hon. Michael Hancock, Authorizing Official/Board Chair, as legal notice to your agency of the results of the program review.

Based on the information gathered during our review, a determination has been made that City and County of Denver is a recipient with at least one area of deficiency in its Head Start and Early Head Start programs.

If you anticipate that you will not be able to correct all findings within the timeframe for correction specified in this report, you must submit a letter to your ACF Regional Office requesting an extension, with an explanation as to why an extension is necessary. The letter requesting an extension must be submitted prior to the expiration of the original corrective action time period.

In order to allow for sufficient time to consider extension requests, we ask that you submit your request within 10 days following receipt of this report. Extension requests shall not be considered approved unless you receive such approval in writing before the deadline for correction.

The report provides you with detailed information on each area where program performance did not meet applicable Head Start Program Performance Standards, laws, regulations, and policy requirements.

Please contact your ACF Regional Office with any questions or concerns you may have about this report.

DISTRIBUTION OF THE REPORT

Copies of this report will be distributed to the following recipients:
Ms. Cheryl Lutz, Regional Program Manager
Ms. Melissa Janiszewski, Chief Executive Officer/Executive Director
Dr. Al Martinez, Head Start Director
Dr. Al Martinez, Early Head Start Director

Glossary of Terms

Compliant	No findings. Meets requirements of Head Start Program Performance Standard.
Area of Concern	An area for which the agency needs to improve performance. These issues should be discussed with the recipient's Regional Office of Head Start for possible technical assistance.
Area of Noncompliance	An area for which the agency is out of compliance with Federal requirements (including but not limited to the Head Start Act or one or more of the regulations) in one or more area of performance. This status requires a written timeline of correction and possible technical assistance or guidance from the recipient's program specialist. If not corrected within the specified timeline, this status becomes a deficiency.
Deficiency	As defined in the Head Start Act, the term "deficiency" means: (A) a systemic or substantial material failure of an agency in an area of performance that the Secretary determines involves: (i) a threat to the health, safety, or civil rights of children or staff; (ii) a denial to parents of the exercise of their full roles and responsibilities related to program operations; (iii) a failure to comply with standards related to early childhood development and health services, family and community partnerships, or program design and management; (iv) the misuse of funds received under this subchapter; (v) loss of legal status (as determined by the Secretary) or financial viability, loss of permits, debarment from receiving Federal grants or contracts, or the improper use of Federal funds; or (vi) failure to meet any other Federal or State requirement that the agency has shown an unwillingness or inability to correct, after notice from the Secretary, within the period specified; (B) systemic or material failure of the governing body of an agency to fully exercise its legal and fiduciary responsibilities; or (C) an unresolved area of noncompliance.

Performance Summary

Applicable Standards	Grant Number(s)	Timeframe for Correction	Compliance Level	Service Area
1302.90(c)(1)(v)	08CH010552	30 days	Deficiency	Supervision
1302.47(a)	08CH010552	30 days	Deficiency	Monitoring and Implementing Quality Health Services
1302.102(d)(1)(ii)	08CH010552	30 days	Deficiency	Reporting

New Deficiency Determination(s)

Supervision
Deficiency 1302.90(c)(1)(v) Timeframe for Correction: 30 days
1302.90 Personnel policies. (c) Standards of conduct. (1) A program must ensure all staff, consultants, contractors, and volunteers abide by the program's standards of conduct that: (v) Ensure no child is left alone or unsupervised by staff, consultants, contractors, or volunteers while under their care.

The grant recipient did not ensure no child was left alone or unsupervised while under the care of its staff. Two incidents of children being unsupervised occurred at the subrecipient's Family Star Northwest Center preschool.

On March 1, 2022, a Head Start child was left unattended on an enclosed playground for approximately 15-20 minutes. A review of documents showed at approximately 1:00 p.m., a child was left unattended on the playground as the remainder of the classroom transitioned indoors. A review of witness statements found the staff counted the children to return indoors; however, one child remained on the playground unaccounted for.

At approximately 1:13 p.m., an Early Head Start (EHS) teacher looked outside and saw the child by the door. The EHS teacher brought the child into her own classroom and called the center director. The center director notified the classroom staff, who were unaware the child had been left on the playground. The program notified the child's parent of the incident on March 1, 2022.

An anonymous report was made to state licensing, who then conducted an interview with staff on May 11, 2022. Licensing determined the child was left unattended on the playground for approximately 15-20 minutes. On June 2, 2022, the program reported the incident to the Regional Office. A review of the employee's consultation form found the primary teacher miscounted children and did not follow name-to-face counting procedures. The teacher received a disciplinary write-up and additional training.

A second incident occurred on September 6, 2022. There was a teacher assistant and a co-teacher with 12 children in the classroom while the lead teacher was on lunch break. When the lead teacher returned from her lunch break at approximately 12:01 p.m., she immediately noticed a child was missing. The front desk staff was notified, and a search was conducted inside and outside the building. The child was found approximately one-tenth of a mile from the parking lot. Upon review of video footage, the child was seen exiting the building at 12:04 p.m. and exiting the parking lot at 12:08 p.m.

In a follow-up interview, the Head Start director shared that due to the commotion of losing and finding the child, no one was entirely sure what time the child left the classroom nor when the child was actually found. Both the co-teacher and teacher assistant were terminated. The child's parent, child care licensing, and the Regional Office were notified on the day of the incident.

The grant recipient did not ensure no child was left alone or unsupervised while under the care of its staff; therefore, it was not in compliance with the regulation.

Monitoring and Implementing Quality Health Services
Deficiency 1302.47(a) Timeframe for Correction: 30 days
1302.47 Safety practices.(a) A program must establish, train staff on, implement, and enforce a system of health and safety practices that ensure children are kept safe at all times. A program should consult Caring for our Children Basics, available at http://www.acf.hhs.gov/sites/default/files/ecd/caring_for_our_children_basics.pdf, for additional information to develop and implement adequate safety policies and practices described in this part.

The grant recipient did not ensure it established, trained staff on, implemented, and enforced a system of health and safety practices that ensured children were kept safe at all times.

On March 1 and September 6, 2022, children were left unsupervised while under the care of staff. As more fully described under 1302.90(c)(1)(v), two children were unsupervised. The pattern of child health and safety incidents indicated the program lacked a system to ensure staff were knowledgeable of and demonstrated adequate active supervision of children.

The grant recipient did not ensure it established, trained staff on, implemented, and enforced a system of health and safety practices that ensured children were kept safe at all times; therefore, it was not in compliance with the regulation.

Reporting
Deficiency 1302.102(d)(1)(ii) Timeframe for Correction: 30 days
1302.102 Achieving program goals. (d) Reporting. (1) A program must submit: (ii) Reports, as appropriate, to the responsible HHS

official immediately or as soon as practicable, related to any significant incidents affecting the health and safety of program participants, circumstances affecting the financial viability of the program, breaches of personally identifiable information, or program involvement in legal proceedings, any matter for which notification or a report to state, tribal, or local authorities is required by applicable law.

The grant recipient did not report to the responsible Health and Human Services (HHS) official immediately or as soon as practicable, related to any significant incidents affecting the health and safety of program participants.

The program had a child supervision incident occur at a subrecipient's center on March 1, 2022. The program did not report the incident to the Regional Office until June 2, 2022, 3 months after the incident occurred. The subrecipient did not report the incident to the recipient after it received the licensing report stating the incident was founded. In a follow-up interview, the subrecipient's center director stated she did not think the incident was reportable.

The grant recipient did not report to the responsible HHS official immediately or as soon as practicable, related to any significant incidents affecting the health and safety of program participants; therefore, it was not in compliance with the regulation.

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