Statement of Deficiencies

1507.C.: Daily Attendance Records - Independent Contactors

1507.C.: Independent Contractors. A daily attendance record for all extracurricular personnel, therapeutic professionals and other independent contractors, to include the first and last name of the contractor, date of visit, arrival and departure times, name of staff member that accompanied contractor, if required, and purpose of the visit.

Finding:

1507.C. Based on record review on 01/14/2019, attendance records for all extracurricular personnel, therapeutic professionals and other independent contractors were not maintained daily as evidenced by the center's visitors daily log dated 11/15/2018 to 1/10/2019 indicate that the daily attendance log failed to include the first and last name of the contractor, date of visit, and departure times for O1 and O2. O1 failed to include her first name and date present in the center. O2 was present in the center on 11/15/2018, 11/27/2018, and 12/04/2018 and failed to sign out each day.

1807.C.: CCCBC-Based Determinations of Eligibility for Visitors and Contractors

1807.C.: C. An early learning center shall obtain a CCCBC-based determination of eligibility for child care purposes from the department for each visitor or independent contractor of any kind, and shall have documentation of said determination available at all times for inspection upon request by the licensing division, unless the visitor or independent contractor, other than therapeutic professionals as defined in §103, will be accompanied at all times while at the center when children are present, by an adult staff member who is not being counted in child-to-staff ratios. The center shall have documentation of said determination of said determination available at all times for inspection upon request by the Licensing Division.

Finding:

1807.C. Based on record review/interview on 01/14/2019, provider failed to obtain a CCCBC-based determination of eligibility for child care purposes from the department for each visitor or independent contractor of any kind or provide proof that the visitor or contractor was accompanied at all times by a staff member not counted in child to staff ratio as evidenced by the center's visitors daily log dated 11/15/2018 to 1/10/2019 indicate that O1 was present in the center without a CCCBC-based determination of eligibility or proof that she was accompanied at all times. Per S1's statement, O1 was accompanied by O3 at all times however O3 is C1's mother and is not a staff member at the center. Specialist was unable to determine date of visit as no date was listed.

1901.J.&K.: Items That Can be Harmful to Children

1901.J.&K.: J. Items that can be harmful to children, such as medications, poisons, cleaning supplies and chemicals, and equipment, tools, knives and other potentially dangerous utensils, shall kept in a locked cabinet or other secure place that ensures they are inaccessible to children. K. Plastic bags, when not in use, regardless of purpose or use, shall be made inaccessible to children.

Finding:

1901.J.&K. Based on observation on 01/14/2019, specialist observed two Stomp and Go stain lifting pads and one small roll of zebra printed plastic bags in S2's classroom located in the second drawer of the black 3 tier plastic cart located on top of the cabinet. Specialist observed three screwdrivers located in a black plastic basket located on top of the wooden cubby shelf located in the rear of S8's classroom. The Stomp and Go stain pad stated to keep out reach of children. These items were not made inaccessible to children or kept in a locked cabinet. S1 removed prior to specialist departure.

1903.C.: Free of Hazards

1903.C.: Indoor and outdoor areas shall be free of hazards.

Finding:

1903.C. Based on observations on on 01/14/2019, the outdoor area was not free of hazards as evidenced by specialist observed two broken red pipes and two broken blue pipes located on the left side of the rear fence on the small playground. S1 removed prior to specialist departure.

1917.D.: Medication Authorization - Non-Prescription Medication

1917.D.: If a non-prescription medication label reads "consult a physician", the early learning center shall also maintain a written authorization from a licensed health care provider for the child to take the medicine.

Finding:

1917.D. Based on record review on 01/14/2019, provider failed to maintain a written authorization from a licensed health care provider prior to administering non-prescription medication to a child as evidenced by the center's medication authorization form dated 01/04/2019 indicate that C4 age one years old was given 2.5 ml of Dimetapp cold and cough without written authorization from a physician. Per the Dimetapp cold and cough directions, children under age six should not use the medication.

Not Met

Not Met

Not Met

Not Met

Not Met

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Not Met

Statement of Deficiencies

1917.H.: Medication Administration Records

1917.H.: Records. Medication administration records shall be maintained for all children regardless of who administers the medication. Records shall include the following:

- 1. name of the child and medication name and dosage administered;
- 2. date and time medication administered;
- 3. documentation of telephone contact with parent prior to giving "as needed" medication;
- 4. signature of person administering medication or witnessing the child administering own medication;
- 5. signature of person completing the form; and
- 6. when a parent administers medication to his/her own child on center premises, the medication administration record shall be documented by either the parent or a staff member.

Finding:

1917.H. Based on record review on 01/14/2019, medication administration records were not maintained for all children as evidenced by the center's medication authorization form dated 11/13/2018 for C3,11/27/2018 for C2, and 01/04/2019 for C4 indicate that the provider failed to document telephone contact with the parent prior to giving "as needed" medication. S9 documented that C2 ,age two years old, received 1 vial of Albuterol however C2 should only have received half a vial of Albuterol per dosage amount documented on the medication administration records form. Per S1's statement, the mother gave C2 one half of the vial each day at home and the center administered the other half at the center however S9 documented the entire dosage. C2 was given one vial each day on 11/27/2018 to 11/30/2018, 12/19/2018 to 12/20/2018, and 1/03/2019 to 1/08/2019.