Statement of Deficiencies

1103.A.-D.: Critical Incidents and Required Notifications — Not Met

1103.A.-D.: An early learning center shall make immediate notification to emergency personnel, law enforcement as applicable, and other appropriate agencies for the following types of critical incidents involving children in care:
1. death;
2. serious injury or illness that required medical attention;
3. reportable infectious diseases and conditions listed in LAC 51.II.105; and
4. any other significant event relating to the health, safety, or well-being of any child, including but not limited to a lost child, an emergency situation, fire or other structural damage, or closure of the center.

B. The parent shall be contacted immediately following any immediate notifications made under Subsection A.
C. The department and other appropriate agencies shall be notified via email within 24 hours of the incident.
D. The department shall be notified by written report within 24 hours of the incident or the next business day. This written notification shall be made on the department's Critical Incidents Report Form and shall contain all information requested on the form.

Finding:

1103.C.&D.: Based on observations/record review/interview(s) conducted on 3/5/2020, at 10:00am: S1 failed to notify the Department within the allotted 24-hours of the following critical incident: on 3/2/2020, at 3:30pm, while playing on the play-yard, C1, a 1-year old, fell from a plastic playhouse hitting her head on the concrete. S1 was informed via text on 3/2/2020, at 4:37pm, by O1, C1's parent, that C1 had a been taken to the doctor to have her injuries further assessed. According to O1, test results indicated that C1 sustained a frontal lobe and orbital fracture. S1 stated she was unaware that she needed to complete and submit a critical incident report (CIR) to the Department in this situation, as she has never had to submit a CIR before. Specialist instructed S1 on where to locate and how to submit a CIR through the Department's website; on 3/5/2020, at 10:55am, S1 completed and faxed a CIR to the Department regarding the incident involving C1 that occurred on 3/2/2020.

Corrective Action Plan: Effective 3/12/2020, S1 stated that she will hold an all-staff meeting to cover the criteria of a reportable critical incident to ensure this deficiency is not recited. S1 will refer to the critical incident guidance form for reference and support.

1711.A.&B.&D.&G.: Child to Staff Ratio — Not Met

1711.A.&B.&D.&G.: A. Child to staff ratios are established to ensure the safety of all children.
B. Minimum child to staff ratios shall be met at all times.
1. There shall be a minimum of two staff members present at an early learning center when more than one child is present.
2. Only those staff members directly providing care, supervision or guidance to children shall be counted in the child to staff ratios.

D. Minimum Child to Staff Ratios for Type II and Type III centers:

Ages of Children	Ratio
Infants under 1 year	5:1
1 year	7:1
2 years	11:1
3 years	13:1
4 years	15:1
5 years	19:1
6 years and up	23:1

G. Mixed Age Groups - Minimum Child to Staff Ratios
1. An average of the child to staff ratios may be applied to mixed age groups of children ages 2, 3, 4 and 5
2. Child to staff ratios for children under age two are excluded from averaging.
3. When a mixed age group includes children younger than age two, the age of the youngest child determines the child to staff ratio for the group.
4. An average may be applied to a mixed age group consisting only of children ages 5 and older.

Finding:

1711.A.&B.&D: Based on Specialist's review of records conducted on 3/5/2020, at 9:45am, on 3/2/2020, S1 failed to meet the required child to staff ratio requirement for children of the following ages: 14 children, one and two years of age, with one staff. The required ratio for children of this age-group is seven children per one staff person. Specialist observed in video footage provided by S1 that on 3/2/2020, S4 was left alone on the play-yard with 14 one-two year olds for approximately nine minutes while S5 went inside the center to assist a child in the restroom.

Corrective Action Plan: Effective 3/12/2020, S1 stated that she will remind staff of ratio regulations/requirements, and during outside play-time, if a child needs to use the restroom, the teacher will be instructed to bring the whole class inside to ensure ratio requirements remain met.

Statement of Deficiencies

1915.B.&C.: Health Services - Parental Notification **Not Met**

1915.B.&C.:
B. Reporting. Incidents, injuries, accidents, illnesses, and unusual behavior shall be documented and reported to the parent no later than when the child is released to the parent or authorized representative on the day of the occurrence.

C. Immediate Notification. The parent shall be immediately notified in the following circumstances:
1. blood not contained in an adhesive strip;
2. head or neck or eye injury;
3. human bite that breaks the skin;
4. animal bite;
5. impaled object;
6. broken or dislodged teeth;
7. allergic reaction skin changes (e.g. rash, spots, swelling, etc.);
8. unusual breathing;
9. symptoms of dehydration;
10. temperature reading over 101° oral, 102° rectal, or 100° axillary; or
11. injury or illness requiring professional medical attention.

Finding:

1915.C.: Based on Specialist's review of records conducted on 3/5/2020, at 10:00am, S1 failed to have documentation of immediate notification to the parent when C1, a 1-year old, fell from a plastic play-house and hit her head on the concrete while playing outside. The incident occurred at 3:30pm, on 3/2/2020, and O1, the parent, was notified at 3:40pm, when O1 arrived to pick up C1. No attempts were made to contact O1 prior to her arriving at the center to inform her of the incident. According to S1 and S4, they did not know when O1 was going to pick up C1 that day; O1 just happened to arrive at the center to do so approximately ten minutes after the incident occurred. S1 stated that C1's injury did not appear to be that serious or she would have contacted O1 right away; there was only a small red mark near C1's hairline. Specialist reminded S1 that any injury to a child's head (above shoulders) warrants immediate parental notification. S1 stated that since only 10 minutes had passed, and had O1 not arrived when she did, S1 would have contacted her to inform her of the incident.

Corrective Action Plan: Effective 3/12/2020, S1 stated that she will hold an all-staff meeting to cover the importance of timely parental notifications to ensure this deficiency is not recited. Incident/Accident reports should be completed as necessary, and all attempts to contact parents documented.