

Statement of Deficiencies

1103-A-D: Critical Incidents and Required Notification

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 Licensing Division and other appropriate agencies shall be notified via email within 24 hours of the incident.
- D. The Licensing Division 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 Licensing Division's Critical Incidents Report Form and shall contain all information requested on the form.

Finding:

1103-C-DCritical Incidents and Required Notification: Based on record review/interview(s): On 5/16/18 the Specialist was informed by S1 that the center failed to notify within 24 hours of the incident the Licensing Section and other appropriate agencies of the following critical incident: On 4/30/18, S1 states that O1 contacted him by phone and asked him if the center gives children Tylenol to make them go to sleep. S1 states that he told O1 no, but failed to notify the Division of Licensing by written report; on the Licensing Division's Critical Incidents Report Form containing all information requested, within 24 hours of the incident of the a parent suspecting unnecessary medicating on or by the next business day. S1 made contact with O1 by text on 5/1/18 and O1 informed S1 that she was upset about the center giving C1 Tylenol. The center again failed to notify the Licensing Division and other appropriate agencies by phone or in writing on the Critical Incident Report that O1 felt that C1 was unnecessarily medicated at the center.

1713-A&B&C: Supervision

Not Met

- 1713-A&B&C: A: Children shall be supervised at all times in the center, on the playground, on field trips, on non-vehicular excursions, and during all water activities and water play activities.
- B: Children shall not be left alone in any room, (except the restroom as indicated in Subsection G or when being provided services by therapeutic professionals as defined in 103), outdoors, or in vehicles, even momentarily, without staff present.
- C: A staff person shall be assigned to supervise specific children whose names and whereabouts that staff person shall know and with whom the staff person shall be physically present. Staff shall be able to state how many children are in their care at all times.

Finding:

1713-A&B&C: Supervision: Based on observation on 5/16/18 the Specialist observed S2 leaving S3's classroom leading a child towards her classroom, which is one door to the right. Upon completing the walk through of the center it was identified that there could not have been a staff person supervising the (2) 6-9 month infants and (1) 1 y/o that was in S3's classroom while she was retrieving the child from S2's classroom because there was only one other staff person on the premises, S1, who was in the cafeteria cleaning up. 3 children ages infant to 1 y/o were left alone in S3's classroom for an unknown amount of time as the Specialist observed S3 leaving S2's classroom as she entered the center.

1725-A.-D.: Medication Management Training

Not Met

1725-A.-D.:

- A. All staff members who administer medication shall have medication administration training.
- B. Whether administering medication or not, each early learning center shall have at least two staff members trained in medication administration.
- C. Such training shall be completed every two years with an approved Child Care Health Consultant.
- D. A licensed practical nurse (LPN) or registered nurse (RN) with a valid nursing license shall be considered to have medication administration training.

Finding:

1725-A.-D.: Medication Management Training: Based on interview(s) the staff person, S4, administering medication did not have documentation of training in medication administration. According to S4 she administered Orajel and Tylenol to C1 on 4/30/18.

Statement of Deficiencies

1917-A: Medication Authorization

Not Met

1917-A: Written Authorization. No medication or special medical procedure shall be administered to a child unless authorized in writing by the parent. Such authorization shall include:

1. name of child;
2. drug name and strength;
3. date(s) to be administered;
4. directions for use, including the route (oral, topical), dosage, frequency, time and schedule and special instructions, if any. It is not acceptable to note "as indicated on bottle"; and
5. signature of parent and date of signature.

Finding:

1917-A: Medication Authorization: Based on record review/interview on 5/16/18 the center did not obtain written authorization from the parent to administer medication to a child as evidenced by S1 and S4 stating that C1 was given Tylenol and Orajel medication on 4/30/18 to relieve gum aching of C1 which was teething. The center failed to be able to provide the Specialist with parental authorization with the medication given.

1917-B: Medication Authorization - Required Container/Packaging

Not Met

1917-B: Required Container/Packaging

1. For prescription medication to be administered at the center, the center shall maintain the original pharmacy container with the complete pharmacy label.
2. For non-prescription medication to be administered, the center shall maintain the original bottle packing for the medicine or a printed document from the manufacturer's website, which shall include the drug name and strength and clear directions for use.

Finding:

1917-B: Medication Authorization-Required Container/Packaging: Based on record review on 5/16/18 the Specialist observed that the center did not have the original bottle packing for the medicine or a printed document from the manufacturer's website, which shall include the drug name and strength and clear directions for use on non-prescription medication to be administered by the center as evidenced by S1 stating that C1 was given Tylenol and Orajel on 4/30/18 for aching gums but he fails to have the original packaging or a printed document from the manufacturer's website.

1917-D: Medication Authorization - Non-Prescription Medication

Not Met

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 Medication Authorization-Non Prescription Medication: Based on record review/interview on 5/16/18 the Specialist observed that on S1 and S4 states that C1 was given Orajel which is a non-prescription medication labeled consult a physician for children under 2 y/o, the early learning center did not have a written authorization from a licensed health care provider for C1 to use the medicine, Orajel on 4/30/18.

1917-H: Medication Administration Records

Not Met

1917-H: 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: Medication Administration Records: Based on record review the center did not maintain medication administration records verifying medication was given according to the parent's authorization as evidenced by on 5/16/18 the center failed to have documentation of medication administration records for C1 who was given Tylenol and Orajel medication on 4/30/18 according to S1 and S4.