Best Child Care
15134 Old Hammond Hwy
Baton Rouge, LA 70816

Date - 10/25/2017
License # - 13567
Action Code - 23 - INCIDENT

Statement of Deficiencies

705.A.B.C.D.: Access — Not Met

705.A.B.C.D.: A. An early learning center shall allow the Licensing Division staff access to the center, the children, and all files and records at any time during any hours of operation or any time a child is present.
B. Licensing Division staff shall be allowed to interview any center staff person deemed necessary by the Licensing Division.
C. Licensing Division staff shall be admitted into a center immediately and without delay and shall be given free access to all areas of a center, including its grounds.
D. If any portion of a center is set aside for private use by an owner of the center, Licensing Division staff shall be permitted to verify that no children are present in that portion of the center and that such private areas are inaccessible to children.

Finding:

705.A Based on interviews: The center did not allow the Licensing Specialist access to all files and records during hours of operation while children are present. On 10/27/17, as part of an incident investigation of suspected abuse of C1, Licensing Specialist requested access to view the center's video footage from 10/4/17, 10:00am-12:45pm. S1 and S2 denied Licensing Specialist access to view this video footage.

1103-A-E: Critical Incidents and Required Notification — Not Met

1103-A-E: 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.
E. Reporting deadlines may be adjusted in the event of a natural catastrophe and/or disaster, as determined by the Department.

Finding:

1103.A-E Based on record review and interviews: The center failed to notify other appropriate agencies(Child Welfare) within 24 hours of knowledge of a reportable critical incident and the center failed to update Division of Licensing with the additional information regarding a reportable critical incident: On 10/3/17 and 10/4/17 O1 observed bruises on C1's torso area, thigh and groin area. O1 took C1 to the physician on 10/4/17 and a report was made to law enforcement of suspected abuse. On 10/5/17 law enforcement visited the center to investigate this incident as suspected abuse of C1. The center submitted a critical incident form to the Division of Licensing on 10/5/17, however the center failed to submit the updated information to Licensing regarding the incident being investigated by law enforcement as suspected abuse.

1911-I.-J.: Proper Lifting of a Child — Not Met

1911-I.-J.: Staff members shall adhere to proper techniques for lifting a child.

Staff members shall not lift a child by one or both arms.

Finding:

1911. I & J Based on record review and interviews: Staff did not lift children in the center using proper lifting techniques. Per Specialist interviews, O1 and O2 observed S12 and S17 lift children inappropriately on three different dates and times: First occurrence, on 8/23/17 between 12:00pm-12:30pm, O1 observed S17 lift an infant by one arm as the child was lying in the crib. Second occurrence, date and time are unknown, O2 observed S12 lift a child by one arm. Third occurrence, on 9/14/17 between the hours of 7:20am-7:30am, O2 observed S12 lift a child by one arm. S1 stated O1 and O2 brought the concerns of their observations to S-1's attention on 9/5/17 and again on 9/15/17. S1 stated she spoke with S12 and S17 regarding improper lifting of children and conducted documented training with all staff on 9/5/17 regarding the proper procedure for lifting children. Per Specialist interviews with S-12 and S-17, both staff admitted that they used an inappropriate method of lifting children in the facility and that S-1 informed both staff on 9-5-17 that a parent informed S-1 that they witnessed S-12 and S-17 lifting children improperly. S-12 and S-17 also admitted that S-3 spoke with them and demonstrated the correct way to lift up a child and they both signed the Memo S-1 drafted on 9-5-17 concerning this topic.

Statement of Deficiencies

1915-A: Health Services - Observation **Not Met**

1915-A: Upon arrival at the center, the physical condition of each child shall be observed for possible signs of illness, infections, bruises or injuries, and when something is observed, it shall be documented and such documentation shall include an explanation from the parent or child.

Finding:

1915.A Based on record review, interviews and observation: Daily observation documentation of the physical condition of C1 was incomplete. Photos provided to Licensing Specialist indicate C1 had visible bruising on his thigh and groin area on 10/4/17. Based on photos provided, the bruising on C1's thigh and groin area would have been noticeable during normal diaper changes on 10/4/17. Daily observation documentation for 10/4/17 notes a diaper rash was observed on C1, but failed to note visible bruising on C1's thigh and groin area. S12 and S17 both deny observing any visible bruising on C1's thighs and groin area during normal diaper changes on 10/4/17.