

Statement of Deficiencies

1103.A.-C.: Critical Incidents and Required Notifications

Not Met

1103.A.-C.: A. 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. a child left unsupervised for any amount of time;
4. use of prohibited behavior management as described in §1509. of this Part;
5. allegations or suspicion of child abuse or neglect by center staff;
6. an accident involving the transportation of children;
7. any child given the wrong medication or an overdose of the correct medication;
8. any loss of power over two hours while children are in care;
9. a physical altercation between adults in the presence of children on the premises;
10. reportable infectious diseases and conditions outlined in LAC 51:II.105;
11. 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. Prioritization of Notifications. The following shall be notified immediately and in the order listed below as applicable:

1. emergency personnel when dealing with any medical incident.
2. law enforcement.
3. parent.

C. The following, as applicable, shall be notified via email within 24 hours of the incident, or no later than the next business day if the incident occurred on a Friday or on a recognized state holiday:

1. LDOE. This written notification shall be made for all of the critical incidents identified above, shall be made on the LDOE critical incidents report form, and shall contain all information requested on the form.
2. DCFS. Report all incidents that might constitute child endangerment including examples provided in mandated reporting training.
3. LDH. Report all incidents related to LDH regulations such as safety and sanitation issues as well as infectious diseases and conditions.
4. OSFM. Report all incidents related to OSFM regulations.
5. Any other appropriate agencies, including but not limited to, local or city fire marshal or the Department of Environmental Quality.

Finding:

1103.A.-C. Based on record review/interview at 1:40 p.m., S1 failed to notify Child Welfare within 24 hours of the following critical incident: On 11/6/2023 at 3:13 p.m., C1, nine months old, fell out of a highchair, due to not being properly restrained in the highchair, after S3 removed the highchair's tray and turned her back to C1. C1 required medical attention. O1 was notified at 3:19 p.m. S1 completed a report Child Welfare during the visit.

Corrective Action Plan: Effective 11/20/23, S1 stated she will report all critical incidents to appropriate agencies, to ensure compliance with this regulation.

1713.E.&F.: Supervision Participation

Not Met

1713.E.&F.:

E: While supervising a group of children, staff shall devote their time to supervising the children, meeting the needs of the children, and participating with them in their activities.

F: Staff duties that include cooking, housekeeping or administrative functions shall not interfere with the supervision of children.

Finding:

1713.E Based on interview/record review at 1:53 p.m., S3 failed to devote their time to supervision of the children, meeting the needs of the children, and in participation with the children in their activities. On 11/6/2023 at 3:13 p.m., after removing the tray of the highchair where C1, nine months old, sat, S3 turned her back to C1, began talking to S2 and wiping the tray to place it into the sink. Neither S2 nor S3 saw C1 fall from the highchair.

Corrective Action Plan: Effective 11/20/2023, S1 stated she will remind staff they must devote their time to the children, to ensure compliance with this regulation

1723.A.&B.: CPR Certification - Infant/Child

Not Met

1723.A.&B.: A. Infant and child CPR. All staff members on the premises of a center and accessible to children shall have current certification in infant and child CPR through training approved by the department.

B. Adult CPR. All staff members on the premises of a center and accessible to children shall have current certification in adult CPR through training approved by the department.

CPR Certification

Statement of Deficiencies

Finding:

1723.A.&B. Based on record review at 3:24 p.m., S1 failed to have documentation that one of seven staff on the premises and accessible to children has current certification in infant, child, and adult CPR through training approved by the Department. S3 failed to have the current certification. A class has been scheduled for 12/1/2023.

Corrective Action Plan: Effective 11/20/2023, S1 stated she will review trainings every six months for expirations, to ensure compliance with this regulation.

1723.C: Pediatric First Aid

Not Met

1723.C: C. All staff members on the premises of a center and accessible to children shall have current certification in pediatric first aid through training approved by the department.

Finding:

1723.C. Based on record review at 2:45 p.m., S1 failed to have documentation that one of seven staff on the premises and accessible to children has current certification in Pediatric First Aid through training approved by the Department. S3 failed to have the current certification. A class has been scheduled for 12/1/2023.

Corrective Action Plan: Effective 11/20/2023, S1 stated she will review trainings every six months for expirations, to ensure compliance with this regulation.

1907.A.1.&. 2: Apparatus or Equipment

Not Met

1907.A.1.&. 2: 1. The manufacturer's restraint device shall be used when equipment is occupied by children.
2. Children who are either too small or too large to be restrained using the manufacturer's restraint device shall not be placed in equipment.

Finding:

1907.A.1. Based on record review/interview at 2:26 p.m., S2 failed use the manufacturer's restraint on the device properly when the equipment was occupied. On 11/6/2023, C1, nine months old, fell out of a highchair because S2 failed to properly use the equipment's restraints.

Corrective Action Plan: Effective 11/20/2023, S1 stated she will retrain all staff on using all required restraints on required equipment, to ensure compliance with this regulation.