Iowa Department of Human Services

CHILD CARE CENTER COMPLAINT

Name of Center: West Branch Community Early Learning Center **Enrollment:** 87 **License ID:** 19820

Street: 400 W Orange ST **City:** West Branch **IA** **Zip Code:** 52358 **County:** Cedar

Mailing Address: 400 W Orange ST

Mailing City: West Branch **IA** **Zip Code:** 52358

Director's Name: Lisa Moore resigned 9/26/2025 **Center Phone Number:** 319-643-7447

On-Site Supervisors: New Director as of 9/27/2025
Joanna Carter **E-Mail Address:** jcarter@west-branch.k12.ia.us

Date of Complaint: 09-23-2025 **Date of Visit:** 09-24-2025

[ ] Scheduled **[X]** Unannounced **[ ]** NA

[X] Non-Compliance with Regulations Found **[ ]** Compliance with Regulations Found

RECOMMENDATION FOR LICENSE

[X] NO CHANGES to licensing status recommended

[ ] PROVISIONAL license from **to**

[ ] SUSPENSION of License

[ ] REVOCATION of License

Complaint Details:

Did this complaint result in a serious injury? ☐ Yes ☒ No

Did this complaint result in a death to a child? ☐ Yes ☒ No

Summary of Complaint:

Several children have been left unsupervised and parents were not notified.

Licensing Rules Relevant to the Complaint:

109.4(1)c Written plan developed for staff orientation regarding center's policies and licensing regulations. Orientation is in accordance with center's staff orientation plan.

109.4(2) Postings are required for:The certificate of license.Notice of exposure to communicable disease.Notice of decision to deny, suspend, or revoke center license or reduce to provisional status.Mandatory reporting requirements.Notice of availability of the handbook.Name and contact information of the HHS licensing consultant.Program activities and menus.All postings shall be conspicuously placed at the main entrance of the center.

109.6(3)b Signed statement indicating they have been informed of responsibilities as mandatory reporters.

109.6(4)c Center repeats Iowa record checks at a minimum of every two years or when aware of additional child abuse or criminal history that occurs.

109.8(2) Ratio maintained in center as required:Brief absence of staff person permitted for 5 or less minutes when another staff person is presentAt least one staff is present in every room where children are resting.If ratio reduced to one staff per room during nap time, does not exceed one hour and ratio in center is still maintained.Ratio in infant rooms is always maintained.When more than eight children are present on the licensed premises, at least two staff members shall be present.For a period of two hours or less at the beginning and end of the center's hours of operation, one staff member may care for eight or fewer children, provided no more than four of the children are under two years of age and there are no more than eight children in the center.Ratio exceeded for school-age children when school classes unexpectedly start late, are dismissed early, or cancelled. For no more than four hours, care is limited to children already in the program and licensed capacity is not exceeded.

109.10(8) Recording incidents: Parents shall be notified on the day of the incident involving a child that includes:Minor injuries.Minor changes in health status.Minor behavioral concerns.Incidents resulting in injury to a child.Shall be verbally notified immediately when there is:A serious injury to a child.An incident resulting in a significant change in health status.An incident includes the child being involved in inappropriate, sexually acting out behavior.A WRITTEN report, fully documenting every incident, shall be provided to the parent or authorized person. This should be completed by staff that witnessed the incident and retained in child file. Serious injuries and deaths must be reported to the Department within 24 hours.

109.10(13)a The center shall have written emergency plans and diagrams for responding to fire, tornado, flood, and plans responding to intoxicated parents and lost or abducted children.Emergency plans shall include written procedures including plans for:Evacuation to safely leave the facility.Relocation to a common, safe location after evacuation.Shelter in place to take immediate shelter when the current location is unsafe to leave due to the emergency issue.Lock down to protect children and providers from an external situation.Communication and reunification with parents or other adults responsible for the children, which includes emergency telephone numbers.Continuity of operations.To address the individual children, including those with functional or access needs.

109.10(14)a The center and supervisor shall ensure that staff knows names and number of children assigned. Staff shall provide careful supervision.

109.11(3)a Center shall ensure that:Facility and premises are sanitary, safe, and hazard free.Sufficient lighting shall be provided.Sufficient ventilation.Sufficient heating.Sufficient cooling.Equipment placed in the program area is maintained so as not to result in injury to the children.

Inspection Findings:

Lisa Moore was the director of West Branch Community Early Learning Center 19820 and West Branch Community ELC-Kids Club 21214. She resigned on 9/26/2025. The director failed to train staff appropriately on mandatory reporter procedures and missing child procedures. The director told staff that if they made a child abuse or neglect report to HHS she would cut their hours or not allow the staff's children to attend the center. The director did not complete incident reports or notify parents/guardians when a child went missing.

Joanna Carter took over as interim director. She has established working relationships with HHS Licensing Consultant and Child Care Resource and Referral.

Unknown date (Summer 2025) an eight-year-old child became angry at staff STAFF A. The child threw a marker and ran off and hid in the building. The staff contacted the director and parent who works at the West Branch Community Early Learning Center 19820. First responders were contacted to help search for the child too. The child was found 1 hour later hiding behind a whiteboard. The child had not left the building

On September 10, 2025, a five-year-old child went inside while being supervised by STAFF A. STAFF A did not notice that the child was inside until the child's mother arrived for pickup and STAFF A didn't know where the child was. The child was unsupervised for at least 10 minutes. The parent was also a staff at the West Branch Early Learning Center told the director. The director stated that if she told HHS then her child would not be able to attend the West Branch Kids Club.

On September 17, 2025, a two-year-old child left the center. Staff member STAFF A was scheduled and working in the room that the two-year-old child was in. STAFF A failed to provide careful supervision. Other staff in the room shared that STAFF A left the room several times and the outdoor play area. STAFF A shared that she was taking children to the restroom. STAFF B and STAFF C did not confirm this. STAFF B and STAFF C shared that STAFF A was talking to the director. During this time that STAFF A was out of the room, children needed to use the restroom. STAFF A was not available to keep the room in ratio STAFF B and STAFF C were not sure where STAFF A was. STAFF B and STAFF C also had no way to communicate with STAFF A. STAFF B took a child into the restroom. This left STAFF C to 11 two-year-old children. STAFF C was on the outdoor play area with all 11 two-year-old children. All staff were aware that the gate was broken. STAFF A was responsible for the care of children and left the room or outdoor play area multiple times. The child was then located in the street by a staff that was not currently working. No one noticed that the child was gone. STAFF A did not search for the child or note that the child was missing. The child was missing for approximately 20 minutes and was in a busy street when found. STAFF A has a history of not providing appropriate supervision to the children that she oversees at the childcare center.

On September 17, 2025, a two-year-old child was left unattended inside of the childcare center for an unknown time frame. While the child was inside unattended STAFF A had been the lead teacher of the child and their other classmates. STAFF A failed to account for this child when the rest of the class had gone outside.

Unknown date: a two-year-old child was left in the bathroom without adult supervision or a light on. The

child was alone for approximately 20 min. STAFF A was the lead teacher in this room.

Within the past three months STAFF A has not provided careful supervision five times and had not accepted responsibility for any of these incidents.

The following is based upon a face-to-face interview with the director/on-site supervisor and staff. Review of administrative items and observations while on-site.

109.4(1)c Written plan developed for staff orientation regarding center's policies and licensing regulations. Orientation is in accordance with center's staff orientation plan.
-The center does have a policy; however, staff did not follow the center's policies. The staff reported that they did not know Iowa Code 109 and Comm. 204.
-This consultant provided the center with Iowa Code 109: https://www.legis.iowa.gov/docs/aco/chapter/441.109.pdf and Comm. 204: https://iowaccrr.org/resources/files/BGP/55%20Comm204.pdf
-CCR&R and the director will develop a staff orientation.
-This consultant attached three examples.
-Joanna developed an orientation plan based on the examples provided. Joanna reviewed Iowa Code 109 and Comm.204 with staff.

109.4(2) Postings are required for: Mandatory reporting requirements.
-Please post this in each classroom: Comm. 076, Your Partner in Protecting Children
-The center had this posted however the director, on-site supervisor, and staff have not followed the requirements.
-The director has informed staff that they only need to make a child abuse report if law enforcement is involved.
-The director did not appropriately train staff.
-The director did not follow mandatory reporting procedures at least three times when informed of abuse/neglect by staff.
-The director told staff that if they made a child abuse or neglect report to HHS she would cut their hours or not allow the staff's children to attend the center.
-Joanna posted updated Mandatory Reporting signs in each classroom including Kids Club and on the parent bulletin board. Mandatory reporting was also discussed thoroughly during staff meetings.
109.6(3)b Signed statement indicating they have been informed of responsibilities as mandatory reporters.
-The director, Lisa, has informed staff that they only need to make a child abuse report if law enforcement is involved.
-The director, Lisa, did not follow mandatory reporting procedures at least three times when informed of abuse/neglect by staff.
-The director has cut staff's hours if they reported. The director also told a staff that if they reported their child would be unable to come to the center.

109.6(4)c Center repeats Iowa record checks at a minimum of every two years or when aware of additional child abuse or criminal history that occurs.
-Two Iowa SING checks were not completed upon my arrival. They were completed while I was at the center.
-Record checks guidance can be found at: https://ccmis.dhs.state.ia.us/providerportal/LicensedProviderDocuments.aspx
-Joanna completed the record checks during HHS visit.

109.8(2) Ratio maintained in center as required.
-STAFF A was to be with the two-year-old children. This staff left the outdoor play area multiple times knowing that a gate latch was broken and that the ratio for this age is 1 to 12. She left two staff alone with the group which would meet ratio requirements; however, another staff member took a child to the restroom leaving one staff to eleven two-year-old children.
-The center director will update/review policies with center staff. Including: breaks, ratios, supervision, etc.
-Joanna shared that counting ratios was reviewed with CCRR representative, then clarified with staff. Extra staff have been assigned to Kids Club as often as possible.

109.10(8) Reporting incidents: Parents shall be notified on the day of the incident involving a child that includes:
Minor injuries. Minor changes in health status. Minor behavioral concerns. Incidents resulting in injury to a child. Shall be verbally notified immediately when there is: A serious injury to a child. An incident resulting in significant change in health status. An incident includes child being involved in inappropriate, sexually acting out behavior.
A written report, fully documenting every incident, shall be provided to the parent or authorized person. This should be completed by staff that witnessed the incident and retained in child file. Serious injuries and deaths must be reported to the Department within 24 hours.

-On three separate occasions children were left unattended. No one completed an incident report or informed parents. On one occasion a child suffered a serious injury. This was not reported to the Department.
-The center director will review this form with all staff. They will ensure that they know when they need to report a serious injury. https://hhs.iowa.gov/media/15928/download?inline
-Joanna shared serious injury reports with staff, as well as when and how to make the report.

109.10(13)a. The center shall have written emergency plans and diagrams for responding to fire, tornado, flood, and plans responding to intoxicated parents and lost or abducted children.
-The center has a written emergency plan. The staff did not follow the emergency plan. The director did not follow the emergency plan. The director did not appropriately train staff.
-The director is encourage to update and review these policies with all staff: https://iowaccrr.org/training/ep/
-Joanna updated emergency plans and reviewed with staff.

109.10(14)a The center and supervisor shall ensure that staff knows names and number of children assigned. Staff shall provide careful supervision.
-Staff did not provide careful supervision. Staff admitted that each person does face-to-name checks the way they choose. There was no training on how to complete face-to-name checks and how often they should be completed. There are many transitions throughout the day. It is vital that face-to-name checks are completed to ensure careful supervision.
-This worker ordered lanyards for them. If they need additional lanyards they can be found at: https://orders.gpo.gov/formOrders.aspx?Appid=70&login=0
-Face to name procedures can be found at: https://www.childcareawareky.org/wp-content/uploads/2025/07/Name-to-Face-Tip-Sheet-pdf.pdf
-Supervision posters can also be a helpful reminder to staff:
https://headstart.gov/sites/default/files/pdf/active-supervision.pdf
https://headstart.gov/sites/default/files/pdf/active-supervision-handout.pdf
https://headstart.gov/sites/default/files/pdf/active-supervision-poster.pdf
https://www.thesilverlining.com/safety-tips/effective-playground-supervision

109.11(3)a. Center shall ensure that: Facility and premises are sanitary, safe, and hazard free.
-Center staff knew that the outdoor gate was fixed. This was reported to the school district. The gate had not been fixed and staff/director did not put a plan in place to ensure careful supervision.

Special Notes and Action Required:

Joanna, the interim director has worked hard to ensure that all staff are appropriately trained. She has a working relationship with HHS and CCR&R.

The director will continue to work with Child Care Resource and Referral Consultant and their Child Care Nurse Consultant until she gains a thorough understanding of HHS rules and regulations.

Care Resource & Referral (CCR&R) Agencies play a vital role in supporting the quality of child care across Iowa by offering both on-site and virtual consultation services to licensed preschools, Child Care Centers, nonregistered Child Care Home providers and registered Child Development Home (CDH) providers. CCR&R agencies assist providers in complying with state regulations by offering expert consultation, training, and professional development opportunities to enhance the quality of care they provide. A key focus is supporting providers in achieving high performance within the Iowa Quality for Kids (IQ4K®) system https://hhs.iowa.gov/programs/programs-and-services/child-care/iq4k, which aims to improve child care quality across the state. In addition to supporting providers, CCR&R agencies also offer parent referral services and consumer education, helping families navigate the child care system and find quality care options.

Child Care Nurse Consultants (CCNCs) are registered nurses who have early childhood training and are experts in child health, child care, and child safety. CCNC services are available statewide and are part of the Healthy Child Care Iowa program. ECE providers may call or email questions to their local CCNC about health and safety policies, health records, health resources, and specific child health or safety concerns. To contact your local CCNC go to https://hhs.iowa.gov/programs/programs-and-services/child-care/hcci and click on the “CCNC Local Services Map”

Consultant's Signature:

Heidi Brown

Date:

10-28-2025