Iowa Department of Human Services

CHILD CARE CENTER COMPLAINT

Name of Center: Loud House Learning Center **Enrollment:** 50 **License ID:** 52455

Street: 204 G Avenue **City:** Grundy Center **IA** **Zip Code:** 50638 **County:** Grundy

Mailing Address: 204 G Avenue

Mailing City: Grundy Center **IA** **Zip Code:** 50638

Director's Name: Brandy Hippen **Center Phone Number:** 319-825-4694

On-Site Supervisors: **E-Mail Address:** loudhouselearningcenter@gmail.com

Date of Complaint: 06-25-2024 **Date of Visit:** 06-27-2024

[X] Scheduled **[ ]** 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:

A complaint was received that a child had eloped from the Loud House Learning Center unknown to staff.

Licensing Rules Relevant to the Complaint:

109.9(2)e Files contain documentation of injuries, accidents or other child-related incidents.

109.10(16)a The center and supervisor shall ensure that staff knows names and number of children assigned. Staff shall provide careful supervision.

Inspection Findings:

A scheduled visit was made to the Loud House Learning Center where this worker, and DHHS co-workers Brian Dietrich and Laura Dhyne met with the center director Brandy Hippen. Brandy was aware of the concern and was able to provide information regarding the child and staff that had been involved. Brandy did state that an incident report had not been completed.

We were able to speak with the staff that had been in the classroom at the time the child eloped from the center, and others that had information regarding the situation. All parties provided consistent and credible information. All parties agree that a child that had been attending the center on Monday, 06-24-24, had left the center. The on-site supervisor, (AM), stated that she had been working in the infant room at the time and a call was received from an individual that is known to the center who lives about 1 1/2 blocks away that they had observed the child walking down the street. In speaking with the employees working in the classroom both confirmed that they were working on opposite sides. It is noted that the classroom is a space that consists of two separate rooms that share an intervening wall with a connecting doorway. One side is used for group learning and quiet table top activities, and the other for center play activities. One employee, (RB), stated she was on the side with the quiet activities with a group of children that were doing puzzles and a magic show and the child identified in the complaint was in the other classroom with the other teacher, (JS). RB stated that Brandy had come down to ask if the child was in the building and RB stated she was not aware that the child or JS had left. RB stated she remained in the classroom with the children.

JS stated that she had been in the classroom on the side with the center activities and the child identified in the complaint had to use the restroom. JS stated that she took the child to the restroom and when returning they entered the classroom on the quiet activities side. JS stated that a couple other children asked her questions while the child identified in the complaint returned to the activity centers side through the intervening door. JS stated she was later told by the other children that the child then proceeded to exit through the entry door to the corridor for that room. JS stated that she began searching for the child in the center and the playground when the center received the call that child had left the center property.

All parties agreed that the child was located at the home of a relative located approximately 6 blocks away from the center after having received a call from that family member that the child was there. All parties agree that the child does have a history of challenging behaviors including situations where the child has left the classroom before to go to other classrooms but this is the first time that the child has left the center property. In reviewing the child's file the center did not have any information identifying any special needs, or care plans that are required or implemented for the child. All parties confirmed that no incident reports had been written. When asked when incident reports are or would be completed the teachers identified that they would do one if a child had an injury, or had behavior such as swearing or being physical with another child.

Based on the information obtained this complaint is SUBSTANTIATED for violation of Licensing Standard 109.10(16)a which requires that the center and supervisor shall ensure that staff knows names and number of children assigned, and staff shall provide careful supervision. All parties agree that the classroom teachers, RB & JS were aware of the children they were responsible including the child identified in the complaint. All parties agree that the class was making use of a space that consists of two connected classrooms with RB on one side, and JS on the other with the child identified in the complaint being on the side JS was supervising. JS stated that after taking the child to the restroom and returning to the classroom on the side that RB had been supervising she was stopped by other children asking her questions and in that time the child entered the other room through the intervening door and then proceeded to exit out the other corridor entry door. JS stated the other children in the room informed her that the child had left and she immediately began searching for the child. All parties agree that the child did leave the center property and was located at the home of a relative approximately 6 blocks away when that family member contacted the center.

Based on the information obtained this complaint is SUBSTANTIATED for violation of Licensing Standard 109.9(2)e which requires that child files contain documentation of injuries, accidents or other child-related incidents. All parties agree that an incident report was not completed. In reviewing the center handbook the center does have policies that do provide guidance on when incident reports are to be completed. While the policies are written in a minimal fashion the staff did confirm that they are to complete incident reports when a child has an injury, or engages in behavioral concerns giving examples of swearing or being physical. While eloping from the center was not identified in the written policy or as an example of a behavioral concern by the staff it is reasonable to assume that eloping from the center would be consistent with the definition of a significant behavioral concern and an incident report should have been completed.

Special Notes and Action Required:

Based on the information obtained this complaint is SUBSTANTIATED for violation of the identified licensing standards. The following actions are required and/or recommended. A full license will remain in effect at this time.

RECOMMENDED:
1. A service referral will be made to Child Care Resource and Referral to assist the center with reviewing and revising the center written policies to provide greater guidance and clarity to staff regarding applicable situations and responses.

2. While all parties agree that the child identified in the complaint has a history of challenging behaviors and is known to be working with other community based services the center had no information regarding providing any additional care or support for the child. It is recommended that the center request information for this, and other children known to have special needs or working with other service to include in the children's files. This can allow the center to provide supportive and consistent care to the children.

3. While the center arrangement does and programming does allow for the splitting of children between the two connected classrooms, and the center did have staff in both rooms it is recommended that the center consider an arrangement of creating smaller classes and just having the children remain in classrooms as a group. This would help to provide improved supervision given that even after it was found that the child had eloped and the staff had gone to look for the child the other classroom teacher identified she was not aware that the child and co-worker had left which would indicate that the other children in that other classroom were also left without direct supervision for a brief period of time.

Consultant's Signature:

Ray Salsbury

Date:

07-09-2024