Iowa Department of Human Services

CHILD CARE CENTER COMPLAINT

Name of Center: Southeast Webster Daycare **Enrollment:** 65 **License ID:** 17940

Street: 104 2nd ST NW **City:** Dayton **IA** **Zip Code:** 50530 **County:** Webster

Mailing Address: 104 2nd ST NW

Mailing City: Dayton **IA** **Zip Code:** 50530

Director's Name: Sara Stevens **Center Phone Number:** 515-547-2200

On-Site Supervisors: **E-Mail Address:** sstevens@svjags.org

Date of Complaint: 03-07-2023 **Date of Visit:** 03-10-2023

[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

Serious Injuries include:

- Disabling mental illness.
- Bodily injury which creates a substantial risk of death, causes serious permanent disfigurement, or causes protracted loss or impairment of the function of any bodily member or organ.
- Any injury to a child that requires surgical repair and necessitates the administration of general anesthesia.
- Includes but is not limited to skull fractures, rib fractures, metaphyseal fractures of the long bones of children under the age of 4 years.

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

Summary of Complaint:

A complaint was received that a child attending Southeast Webster Daycare received a broken leg due to an unknown cause while at the center.

Licensing Rules Relevant to the Complaint:

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

109.12(2) Center shall have written policy on discipline of children which provides for positive guidance, with direction for resolving conflict and setting of limits.

Inspection Findings:

A call was made to the center on 03-08-23 where I spoke with the center director, Sara Stevens, who confirmed that she was aware of the concern and a visit was scheduled for a time when the staff who had been involved in caring for the child and responding to the incident would be available.

A scheduled visit was made to the center on 03-10-23 where IDHHS co-worker Melissa Allison, Webster County Deputy Alex Winninger, and myself met with the center director Sara Stevens. Sara was asked what she was aware of regarding the injury. Sara stated she had been off work at the time and received a call from the teacher (SW) that was the on-site supervisor at the time. Sara stated that SW asked her to come back to the center to check on the child who had an injury to the leg. Sara stated she did contact the school principal who confirmed that she had called for an ambulance. Sara stated that when she arrived SW was holding the child on her lap with the child's leg out of the sleep suit the child was

wearing. Sara stated she inquired if the parent(s) had been notified yet and she was informed they had not so Sara contacted the child's mother. Sara stated that when the mother arrived she drove the mother to the hospital. Sara stated that the was told that the staff initially thought the child had been sick and so had checked the child's temperature and it was when SW was assessing the child that she discovered the leg injury. Sara stated that the child identified in the complaint is a mobile infant. Sara stated that there was no report of any furniture being tipped over through there is a small shelf the children in the room do try to climb. Sara stated that the child is not a difficult child with regard to behavior or care needs. Sara stated that the child does have some limited verbal skills and when she arrived she did talk to the child. Sara stated that she did ask the child if they fell and the child said, "yeah" and identified a peer suggesting the peer had pushed the child. Sara was able to provide the information regarding the staff that had been in the classroom at the time, and who had responded to the situation. Sara was also able to provide copies of the incident summaries completed by those employees. As noted SW was the on-site supervisor at the time, and there were two teachers who had been in the classroom, AM, and AK.

In reviewing the written incident summaries AM identified that on 03-07-23 she was changing a diaper for a peer at approximately 3:50 PM and could see the identified child playing with another peer by a shelf and walking around. After AM completed the diaper change she saw that the child was sitting and crying and assumed that it was because the peer a toy and the child wanted the same toy. AM stated she got both children a doll and that didn't help. AM stated that she noticed the child shaking and she told her co-worker AK who took the child to SW. AM noted that is the last she saw of the child.

The written incident summary completed by AK was dated 03-08-23. AK estimated the time to be around 3:30 pm when AK was in the laundry room. AK stated that when she came out of the laundry room she observed the child sitting on the blue mat by the laundry room. AK stated she picked the child up and placed the child in a crib while AK washed her hands. AK stated that the child continued crying and so AK checked to see if the child needed to be changed but the child was clean and dry. AK stated she placed the child back on the blue mat and went into clean the changing station and wash her hands. AK stated when she came out of the restroom where the changing station is located the child was still crying and started shaking so AK took the child to SW who questioned if the child was sick and if AK had checked the child's temperature. AK stated she took the child back to the classroom to check her temperature which was normal. AK stated she took the child back to SW who found something with the child's leg.

The incident summary completed by SW identified the date and time to be 03-07-23 around 3:45 pm and that she was working in the school age room when AK came in with the identified child carrying the child on AK's hip. AK told her that he child was fussing/crying and shaking and she didn't know why. SW stated she asked AK to check the child's temperature, and also gave AK a bucket as she though the child might throw up. SW stated that AK left to check the child's temperature and returned noting the child did not have a temp. SW stated that she took the child from AK and began to look the child over. When SW began to take of the one piece pajamas she immediately knew the leg was broken as she felt the bones grind so she stabilized the leg and immediately called for help.

We did conduct interviews with SW, AM, and AK individually. Each employee provided statements that were consistent with the written summaries they had provided. AM did provide additional information identifying that after she finished the diaper change the identified child had been by a red Boppy by the rug across the room when she gave the child the toy to play with, and later the child had moved to the shelf by the bathroom. AM stated she did not observe the child moving so she did not know if the child walked or crawled to the location. AM also clarified that the child had not received a diaper change that afternoon. AM stated that the child had woke up from a nap at around 2:00 pm and AK checked the child who was clean and dry and so did not do a diaper change.

All staff provided consistent and credible information that the child identified in the complaint is a healthy child that is active. All stated that the child does not have any known health concerns and is developmentally normal. All stated that the child does not have any behavior concerns. All denied having any concerns regarding any co-workers in the center. All staff agreed that each classroom in the center was in ratio on the day of the incident and specifically in the infant room where 2 staff were present with 6 or 7 children. The staff to child ratio requirement for infants (children under 24 months) is 1:4. When asked about the locations of the other children all parties agreed that the identified that AM had one child on the changing station, the identified child and another same age older peer were in the primary play area, the other mobile infants were in bouncers, and the non-mobile infants were on the play mat. All parties were unable to provide any specific known or theorized cause of the injury, but were able to establish a window of approximately 2 - 2 1/2 minutes during the time when AM was changing a child, and AM was attending to laundry as the timeframe of when the injury occurred.

In observing the room the layout is a large rectangular shape with an attached bathroom, and a laundry room on one end. The changing station is located just inside the doorway of the bathroom. Located just outside of these areas is the primary play area of the classroom. Cribs and a feeding area are located on the other end of the room. The arrangement is such that there would be limited sight lines

from the bathroom changing station where a teacher would be able to see the primary play area of the room if the door were left open but would not be able to see the full room. The laundry room arrangement is such that the machines and work areas are placed where an individual interacting in those areas would have little to no sight lines of the classroom if the door were left open. The room does not have any video monitoring system.

A return visit was made to the center on 03-21-23 by this worker, Melissa Allison, and Deputy Winninger to complete interviews with other staff at the center, and to clarify some information. We did speak with JP who confirmed she had been asked to go to the school age room to take over/swap with SW on 03-07-23. JP stated that the child did have the injured leg removed from the pajama leg the child was wearing. JP stated that she did not have any concerns with regard to the staff who had been working with the identified child.

We next spoke with the school principal who confirmed that she had been in the school office when she received a message that the daycare needed help. The principal stated that when she arrived at the daycare SW had the child sitting on her lap and she questioned what had happened and SW stated that they did not know. The principal stated that the school nurse was not in the building so she called 911 for an ambulance. The principal did confirm that the child's injured leg had been removed from the pajama leg when she arrived. The principals stated that the child had been crying but was fine when she arrived and did not start crying again until the ambulance crew arrived. The principal stated she was not aware of any concerns regarding any of the staff at the center but did not that she does not have much involvement with the daycare.

In speaking with SW it was clarified who had removed the child's leg from the pajamas the child was wearing. SW stated that she was not sure who had done that but assumed that she had been the one to do so and that was when she felt the grinding of the bone.

AK was able to clarify that the child and peer were arguing over a toy and she did give them another doll to play with before AK went into the laundry room. AK confirmed that the door was closed and she did not direct line of sight but did hear the child begin crying and assumed it was because the peer had taken the doll from the child again. AK did confirm that AM was still changing the diaper for the peer she had been changing when AK went into the laundry room. AK also clarified that the child had been sitting on the blue mat by the laundry room and changing station area both before and after AK was in the laundry room.

AM was able to clarify that the child was playing by the shelf near the bathroom and laundry room, had moved to the rug across the room by the Boppy where she was crying, and then back to the blue mat. AM did confirm that the child had not received a diaper change yet as the child was clean and dry when getting up from napping, and AM had not yet gotten to the child for a change before the child started crying.

Based on the information obtained this complaint is NOT SUBSTANTIED for violation of Licensing Standard 109.12(2)a-d which requires that among other things the center shall have written policy and practice on discipline of children which provides for positive guidance, with direction for resolving conflict and setting of limits and prohibits the use of corporal punishment and other specified punishments. All parties provided consistent and credible statements that there was no behavioral concern regarding the child where a staff member responded to a behavioral issue with implementing any physical or other form of discipline. All parties agree that the only behavioral concern involving the child was competing with a peer over a toy and the staff addressed this by providing both children with a doll to play with.

Based on the information obtained this complaint is SUBSTANTIATED for violation of Licensing Standard 109.10(16)a which requires 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 was in ratio with 2 staff and 6 or 7 infants, and both teachers were able to identify the children who were in their care at the time. All parties agree that both AM and AK were engaged in routine caregiver tasks throughout the day. While both AM and AK were unable to identify or theorize a cause of the injury they were able to narrow the timeframe to a window of opportunity to an estimated 2 - 2 1/2 minute window when AM was engaged in a diaper change, and AK was engaged in activities in the laundry room based on the child moving an acting normally up to that period, hearing the child begin crying during that period, and being symptomatic after that period. Both AM and AK agreed that the door to the bathroom where the changing station is located was open when AM was engaged in the diapering activity, and the door to the laundry room was closed when AK was attending to the laundry activities. This did result in a situation where the level of supervision in the classroom was reduced as AK would have her attention focused on the child for whom she was changing a diaper, and AM was in a position to be unable to provide any supervision for any of the children. This is especially concerning given that infants are fully dependent on others to meet their care needs, and are unable to recognize and/or remove themselves from dangerous situations. A reasonable alternative would have been for AM to wait until AK had finished the diaper change she was engaged in and back to a position of being able to provide full supervision to the room and children before AM entered the laundry room.

Special Notes and Action Required:

This complaint is SUBSTANTIATED for violation of Licensing Standards and the following actions are required and or recommended. A full license will remain in effect at this time.

RECOMMENDED:
1. The center should review practice and consider the development of a center based policy regarding supervision and staffing when engaging in non direct caregiving activities, or other activities that can reduce the supervision or attention to the child programming in the room. While Licensing Standards do allow for reductions in ratio in specific circumstances it is still incumbent upon the center and staff to ensure that children are supervised and their care needs met. Staff are frequently engaged in non direct care activities such as charting, laundry, cleaning, etc. and while these actions are also necessary and required the staff can coordinate these at times such as during nap, when going to or returning from break when relief staff are present, the end of the day, or when a coworker is able to provide more focused supervision.

2. The center should consider the option of installing a video monitoring system that has the capability to observe all areas of the programming spaces, and the ability to maintain recordings for review.

Consultant's Signature:

Ray Salsbury

Date:

03-30-2023