

On 3/24/15 information was obtained from the local CCRN consultant who has been working regularly with this center that this same staff person, Theresa, was overheard by the CCRN consultant yelling during a visit the CCRN consultant was making at the center. The CCRN consultant went to that room immediately and described that the staff person continued to talk to the children in a loud voice even with the CCRN person there. The CCRN consultant made the center director aware of the concerns immediately.

On 3/25/15 an unannounced visit completed at the center to follow up on this incident. Licensing consultant met with center director and business manager. Kari and Lisa confirmed the information presented above. Kari stated Theresa was a floating staff who would spend most of her time in the three to five year old room. When the incident occurred it was during staff break time when Theresa would have been filling in in the one year old room.

Kari stated when the CCRN consultant came to her with the concern about voice tone for Theresa, it was not the first time within a couple day period that Kari had been approached with this concern. Kari checked her written notes and stated she had approached Theresa on 1/28/15 to specifically discuss voice tone. Kari stated from that point, Kari felt like Theresa was doing better with this whenever Kari was observing Theresa. Kari stated with this history, when the incident occurred with the child being injured, the center was just done with Theresa and decided to dismiss her.

It is noted that information from DHS Oldsent indicated there was some concern that the center did not immediately notify the mother of the incident. Additional follow up with the center director clarified that the center did not become aware that there was an injury to the child until after the child went to the doctor. The center director stated she called the mother at work after she became aware of the incident and asked the mother to see her at pick up so that they could discuss the incident. The center director stated at the time of the phone call she told the mother that there had been an incident but that the child was okay. The center waited to detail the mother about the incident until the mother came to pick up the child at the regularly scheduled time. The center director stated the child acted normally after the incident, so the center was not aware of the injury at the time.

The staff file was reviewed and it was discovered that the SING record check was not completed prior to staff Theresa's involvement with child care at the center. The center is cited for this, and these requirements were again discussed with the center.

Special Notes and Action Required:

The incident did occur and it appears likely that the child's injury was a result of the staff person carrying the child inappropriately and in an unsafe manner. It does appear that the center responded to the incident timely, and the result was a decision by the center to terminate the staff person's employment at the center based on this incident and some history of working with this staff person already on issues such as inappropriate voice tone with the children.

As stated above this center has already been working with the local CCRN consultant on a regular basis for center improvements. The center director stated she has already been working with the CCRN consultant on identifying and scheduling the most appropriate trainings for staff in conjunction with this incident.

The center will need to ensure that mandatory abuse reporting procedures are followed. Some review of these procedures would be beneficial to ensure suspected abuse is reported timely.

The center needs to ensure that background checks are completed timely as required by rule.

Heidi Hungate, MSW
DHS Child Care Licensing Consultant

Consultant's Signature:



Date:

03/30/2015