



**Inspection Findings:**

An unannounced visit was conducted to St. Matthew Early Childhood Center on 10/27/2014. The following is based upon observations while on-site, a face-to-face interview with director Becky Rasmussen, and a face-to-face interview with two staff in the infant room area:

109.9(4). Daily written records are maintained for each child under two years of age and include time periods slept, amount of time/food consumed, time/irregularities of elimination patterns, general disposition, and general summary of activities. Staff shall record information as it occurs and not rely on memory at the end of the day in composing a record of events. COMPLAINT IS VALID. The first incident reported above (#1) happened a few months prior to being reported to management or licensing. As a result, it is difficult to state exactly what did or did not occur as staff are not able to recall any such incident. On 10/16/2014, the written daily sheet did not accurately reflect what the infant ate that day. It is important to note, the infant was offered and ate table food that day in addition to 2 bottles of formula. Ms. Rasmussen reported the infant is in the process of transitioning to a cup and some of the 3rd bottle may have been placed into a sippy cup. Prior to 10/17/2014, Ms. Rasmussen reported staff in infant room A and infant room B were moving children back and forth between the two rooms throughout the day. Ms. Rasmussen talked about how this practice has stopped since she became aware of the complaint and what was happening. Ms. Rasmussen reported infants are now only moved between the two rooms at management's direction. Ms. Rasmussen talked about how parents do take their infant's bottles home each night for cleaning and sanitizing only to return with clean and sanitized bottles the next day. Ms. Rasmussen reported if parents bring pre-made bottles into the center, the bottles are to be labeled and dated. Infant bottle storage in the refrigerator and freezer was observed. Bottles are labeled. Staff reported having their own internal systems of checks to ensure the right bottle is fed to the right baby. Ms. Rasmussen and I discussed obtaining separate containers for each child's bottles to be stored inside the refrigerator to help further prevent any bottle mix-ups. Staff reported completing each infant daily sheet as the day progresses rather than trying to recall from memory.

109.10(3)a and b. Medications stored inaccessible to children and public. Nonprescription medications labeled with child's name. Notation of administration of medication for every day authorization is in effect and child is in attendance, including medication, date, time, dosage, and initials of person administering. If medication not given, a reason is cited. COMPLAINT IS VALID. Ms. Rasmussen reported the incident involving the medication was brought to her attention shortly after it happened the first week of the 2014-2015 school-year. The Wal-Mart children's acetaminophen bottle was observed to be labeled with a child's name. The medication was also observed to be unopened with the plastic safety wrapping still intact. Ms. Rasmussen agreed the child's name was misspelled. Ms. Rasmussen stated she looked at the handwriting on the bottle of medication and believes it had been labeled by a staff who no longer worked/works at the childcare center. Ms. Rasmussen stated staff are aware that any medication is not to be stored in children's cubbies but handed to the parents at either drop-off or pick-up. Ms. Rasmussen reported she did review this with all staff to ensure the program's policies are being followed. Ms. Rasmussen also reported the program's new policy is that when a child is switching rooms (example from the 2-year-old room to the 3-year-old room), all the child's belongings (bedding, extra clothing, any medications, etc.) are sent home with the parents the day prior to the switch. Ms. Rasmussen talked about how the parents are now responsible to bring everything the child needs when starting in a new room rather than staff just moving the child's belongings from the old room to the new room. Ms. Rasmussen stated she is not sure exactly what happened regarding the medication as the staff involved no longer worked at the child care center by the time the incident was reported to her. Ms. Rasmussen reported a medication authorization for the Wal-Mart children's acetaminophen was not found and the medication was not given to any child as it is unopened with the safety plastic still intact. Ms. Rasmussen reported the medication will be disposed of.

**Special Notes and Action Required:**

Based upon the above, no written response to this report is requested.

If you feel something is unclear or unjustly cited, please contact me (phone 319-892-6827; email [alyons@dhs.state.ia.us](mailto:alyons@dhs.state.ia.us) <<mailto:alyons@dhs.state.ia.us>>) so that we may discuss the issue. If necessary, I can make a notation in your record. You may also send a letter that will be included in your licensing file noting any disagreement you may have with this report. If I have failed to provide for you any information discussed during my visit, please contact me and I will forward the information to you. Thank you.

**Consultant's Signature:**



**Date:**

11/04/2014