

**Iowa Department of Human Services
CHILD CARE CENTER COMPLAINT**

Name of Center: Children's Choice Early Learning Center	Enrollment: 221	License ID: 4182000110
Street: 115 S 3rd Ave	City: Eldridge	IA Zip Code: 52748
County: Scott		
Mailing Address: 115 S 3rd Ave		
Mailing City: Eldridge	IA Zip Code: 52748	
Director's Name: Karen Blend	Center Phone Number: 563-285-6500	
On-Site Supervisors: Karen Blend	E-Mail Address: karenbece@yahoo.com	

Date of Complaint: 3/10/2014

Date of Visit: 3/25/2014

Scheduled Unannounced NA

Non-Compliance with Regulations Found Compliance with Regulations Found NA

RECOMMENDATION FOR LICENSE

NO CHANGES to licensing status recommended

PROVISIONAL license from _____ **to** _____

SUSPENSION of License

REVOCATION of License

Summary of Complaint:

Center is not following guidelines as discussed with the parent for transitioning a 21 month old child from one room to the next. The child has had asthma attacks due to anxiety as a result. The same child was in the hall and screamed for 1.5 hours on one occasion. The child's face turned purple and the child needed the child's inhaler.

There is a no contact order between the parents of a child. The father's cousin works at the center, and the child was allowed contact with that staff person even though that child's mother asked the center not to allow this.

Staff Diana was observed shoving food into a 21 month old child's face and pouring milk in the child's mouth. The child coughed and struggled to breathe. This happened about a month ago. The director was told of this, and she stated she was aware of it but if there was no date provided for when it actually occurred she could do nothing.

The center director has "bullied" the staff and asked staff not to be honest with parents.

Licensing Rules Relevant to the Complaint:

109.10(16) Supervision and access.

a. The center director and on-site supervisor shall ensure that each staff member, substitute, or volunteer knows the number and names of children assigned to that staff member, substitute, or volunteer for care. Assigned staff, substitutes, and volunteers shall provide careful supervision.

109.12(2) a-d Discipline does not allow - corporal punishment; punishment that causes humiliation, fear, pain or discomfort; locking children in an area or using mechanical restraints; associating with illness, toilet training, food or rest; or the use of verbal abuse, threats, or derogatory remarks about a child's family.

Inspection Findings:

The center was visited on 3/25/14 unannounced to discuss the complaints. The center director, Karen Blend, was interviewed along with several other staff, separately. The center owner, Shari Eller, was also present and part of some of the conversation with the director.

Karen was familiar with the concerns reported for the child with asthma. Karen described that there had been some difficulty in transitioning the child from the younger toddler room to the older toddler room, and much discussion had been going on back and forth with the child's mother relative to this. The mother of the child reported to the center that the child had night terrors and high anxiety that would trigger asthma. Karen stated she had always gone along with the mother's requests in regards to the transition plan. Karen described that the plan often got confusing on the mother's part. Karen stated there had also been discussion that the mother did not want the child around a particular staff in the new room. Karen stated the mother reported the child would get night terrors when around that staff. Karen stated she was able to accommodate this wish when working the transition plan because she would swap out the staff between the rooms as the child was transitioning as well. Karen stated the child did not appear to be having any problems with this and on one day the child simply ran over to the new room on his own. Karen stated it was on this particular day that the mother came to the center shortly after this and found the child in the new room, and the mother was instantly upset. Karen stated things happened so quickly that she had not yet been able to call the mother to tell her about the transition on that day. Karen stated on this day the child started crying when the mother came but this was because the child was not ready to leave. Karen stated the mother was very angry with Karen and accused Karen of lying to her, etc. Karen stated the mother stated that she was done with the center. The child has since been brought back to the center.

Karen described ongoing problems between the staff in the two toddler rooms. The two rooms are adjoined by a door, and the staff in these rooms work together to transition children from one to the next. One of these staff also had a verbal altercation with another staff in the hallway of the center as observed by Karen. Karen stated that staff and two of the other staff in one of those toddler rooms have since left the center because of the problems.

Karen stated she was not aware of any incident that any child would have been left in the hallway crying for any period of time nor did she administer the child's inhaler for any reason as such. Karen stated she is the one who would have administered the inhaler. Karen brought out the documentation for the child's inhaler, and the child had not used it at all this month. As of February, Karen also noted that the mother discontinued the regular doses of the inhaler and went to only as needed.

Karen stated she was provided, in writing, a concern from one of the staff about staff Diana shoving food in a child's mouth and pouring milk into the child's mouth. Karen stated the note was from a staff in the other toddler room (not the room Diana works in). Karen stated that Diana is the staff in Sprout Court (one of those toddler rooms). Diana has completed PITC training. Karen stated she knows that Diana does help the children as they transition to using cups rather than sippy cups. She stated the children feed themselves in this room, but Diana may assist them when needed. Karen stated she pulled Diana in to talk with her on the day that Karen received the concern. Karen stated Diana stated she would have just been encouraging the child to eat by putting the food or drink to the child's lips. Karen stated Diana denied doing this in a malicious way or that she choked or made the child cough. Karen stated she never actually had a conversation with the staff who left her the note reporting the concern.

In regards to the no contact order situation, Karen stated she became aware that the father of the child was a third or fourth cousin to a staff works at the center. Karen provided a copy of the no contact order from the child's file. Karen stated the child has been in the Huggable Hills room since 1/2014. The relative staff works in Adventure Place which is the adjoining room. Karen stated when she found out about the relation, they called the staff in to talk with her and to advise her to be careful. Karen stated the staff denied that she even really knew the father. Karen stated they left it at this because they really did not know what else to do at this point.

The licensing consultant spoke with two other staff separately who work in either of the two toddler rooms and also with staff Diana. The staff indicated knowing that one of the staff who no longer works at the center was friendly outside of the center with the parent of the child with asthma. The staff felt that there was likely miscommunication between all parties involved, including the mother, when it came to the transition plan for the child and that the plan was not always clear. The staff also indicated knowing that the staff who no longer work at the center had problems with staff Diana. The staff indicated that they never saw a concern of how Diana interacted with this child or any other child but that Diana is an older staff (than the other staff involved) and may be perceived as a bit bossy at times. One of the staff indicated Diana is the best teacher they have and stated she knew that the staff in the other room did not like Diana. Staff Diana stated there was always a lot of "drama" between the two rooms. She denied that she had ever caused a child to choke or not be able to breathe. She stated the children are just learning to use regular cups when they come to her room. All of the staff indicated that the relationship between the two rooms is much better since the three staff are no longer at the center. None of the staff indicated that they had been bullied by Karen or told to be dishonest to parents.

Special Notes and Action Required:

There is not definitive information indicating that the center has violated rules relative to this complaint at this time.

The center may want to consider a written transition plan in a situation such as this where the transition may be more complicated than normal and then updating that plan, again in writing, with the parent so that all parties are clear on what is to happen. This written plan then needs to be provided to the staff in the rooms so that they have the most current plan and can follow through accordingly. This avoids any confusion for any parties.

The center should also consider documenting better reported incidents involving staff and to follow up with the involved staff and document that follow up. It would have also been a good idea for the director to have had a conversation with the staff who left the note on her desk with a concern and to also document this conversation. It would be the expectation that the staff in these two rooms would work together as their jobs relate regardless of their personal feelings toward one another. The director should become involved and possibly consider disciplinary action with the staff if this is compromised to the extent that the staff are refusing to communicate or work together for what is required for the children.

Discussion also occurred regarding the center's cell phone policy. Through this discussion it was determined that the center needs a stricter policy to ensure that staff are not checking/using their cell phones when staff are in ratio and expected to be involved in program activities with the children. The licensing consultant supports the center in developing and enforcing a stricter policy with staff in regards to this issue.

There are no further actions requested from the center as a result of this report.

Heidi Hungate, MSW
DHS Child Care Licensing Consultant

Consultant's Signature:

Date:

04/28/2014

