Iowa Department of Human Services

CHILD CARE CENTER COMPLAINT

Name of Center: Raisin' Em Up Early Learning Center **Enrollment:** 40 **License ID:** 20181

Street: 607 Park St **City:** Donnellson **IA** **Zip Code:** 52625 **County:** Lee

Mailing Address: PO Box 159

Mailing City: Donnellson **IA** **Zip Code:** 52625

Director's Name: Sarah Tweedy **Center Phone Number:** 319-470-4351

On-Site Supervisors: Laura McDowell and Nichole Loges **E-Mail Address:** stweedy@hotmail.com

Date of Complaint: 04-19-2019 **Date of Visit:** 04-22-2019

[ ] Scheduled **[X]** Unannounced **[ ]** NA

[X] 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

[X] 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:

B.G. was inadvertently given 2 doses of amoxicillin on 3/4/19. This is the second time in two months children have been overmedicated while in care.

Licensing Rules Relevant to the Complaint:

109.10(3)b For every day an authorization for medication is in effect and child is in attendance, there shall be a notation of administration including the name of medicine, date, time, dosage, given or applied, and the initials of the person administering the medication or the reason the medication was not given.

Inspection Findings:

The determination of this complaint was made based upon employee/Director and parent interviews, a review of training requirements, and independent evidence in the form of messages provided by the DCI. I made an unannounced visit to the center and have made weekly visits since that time. The Director and I have discussed this allegation.

1. 109.10(3)b For every day an authorization for medication is in effect and child is in attendance, there shall be a notation of administration including the name of medicine, date, time, dosage, given or applied, and the initials of the person administering the medication or the reason the medication was not given.

In the Medication Errors portion of Medication Administration training in Essentials, (which is required

training), the training states, "If a child is given the wrong medication IMMEDIATELY call the Poison Control Center at 1-800-222-1222. All errors must be recorded on Child Incident/Injury Report Form. A copy of the form should be provided to child's parent or guardian and the original form should be placed in the child's filed. The Child Injury/Incident report form can be found on the IDPH Healthy Childcare Iowa website under "products". A medication incident report from can also be found in Caring four Our Children: Appendix AA

DHS received evidence regarding Director Tweedy not completing Essentials training as indicated in messages between her and Laura M. Essentials training covers medication administration. In February 2018 Sarah stated, "12 hours of training hours". Laura M. states, "What is your password, I will work on it in a.m.". Director Tweedy answers "Lol, idk." Laura responds, "You should get an email." Director Tweedy responds, "For CACFP or other thing".

In September 2018 Laura M. stated, "I will try to get your Essentials done." Staff members Korissa H. and Bailey J., were also aware that Laura M. completed online training requirements for Director Sarah T. According to the DHS Training Registry Director Tweedy did not take medication administration which is a required course until January 2019.

B.G. was given a double dose of amoxicillin on 3/4/19 by staff member Jordan B. An incident report was filled out for this incident, which I reviewed. I spoke with B.G.'s mother and she indicated she was notified immediately, that she called her physician and the physician called poison control. On 3/4/19 the center did not utilize the medication administration log making notation of medication administration including the name of medicine, date, time, dosage, given or applied, and the initials of the person administering the medication or the reason the medication was not given. This caused a child to receive a double dose of Amoxicillin.

Jordan B. had medication training on October 8, 2018.

Staff must have accurate and precise information regarding a child's need for medication before administering any medication. Keep all authorizations and medication administration forms on site where the children are located and not in a central record depository in another building. Director Tweedy did not inform poison control as directed.

Prior to this specific incident another young child, L.M. was given a double does of Tylenol on 1/22/19. This error is specifically addressed in a separate report.

On at least 2 occasion 1/22/19 and 3/4/19 the center did not utilize the medication administration log when 2 children were given double doses (of Tylenol in one case and Amoxicillin in one case). The program Director Sarah T. did not take medication administration which is a required course until January 2019. She began the training on 1/2/2017 and requirements state the training should have been completed within 90 days. Only after a complaint on a separate issue lodged in December 2018, did Tweedy complete Essentials training requirements in anticipation of a training record review. The center did not call poison control as indicated in training. As the center leader (Director) it is imperative to have current health and safety trainings. Medication administration and knowledge about caring for children with special health care needs is essential to maintaining the health and safety of children with special health care needs. The other incident regarding dispensing medication erroneously is covered in another report. Had staff followed protocol and utilized the medication administration sheet and had proper guidance from leadership these mistakes would not have occurred. ---VIOLATION

The Director reported these mistakes have been addressed and stated, "at the next staff meeting I discussed errors and made a plan of how to make sure not to happen again. Also Laura and I both attended the New Medication Handling class and used the things learned from that training for all staff." Staff meetings are held monthly. The Director states no medication errors occurred prior to the onsite supervisor's (who was also the center nurse)absence in December 2018. She reports at the March 2019 staff meeting she presented to staff medication administration information she learned at the class.

Special Notes and Action Required:

*Note: If you are the Child Care Center Director and you feel something is unclear or unjustly cited, please contact me (phone 641-684-3951; email jseiber@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 you have the need for any additional information discussed during my visit, please contact me and I will forward the information to you. Thank you.

*Note: If you are a member of the general public, there may be additional information contained in the public file. You may contact the DHS Licensing Consultant to inquire.

A referral for technical assistance was made to your local Child Care Resource and Referral agency for the following reason:

[ ] Safe Sleep Practices

[ ] Emergency Preparedness Planning

[ ] Discipline Strategies

[X] Other

Consultant's Signature:	**Date:**
Jill Seibert	06-12-2019