



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

February 3, 2023

Kaitlin Allen
Spartan Kid Care Inc
1730 Crescent Road
East Lansing, MI 48823

RE: License #: DC330018010
Investigation #: 2023D0109004
Spartan Child Development Center

Dear Ms. Allen:

I conducted a special investigation because the child care licensing bureau received information regarding your facility that related to licensing rules or law. The information was related to the following:

R 400.8125 Staff; volunteer; requirements

The details of the information are in the attached report. To investigate:

- I interviewed the office manager, child care staff members, and parents.
- I completed on-site inspections on the following dates: 01/18/2023 and 01/19/2023.

As a result of this investigation, I found the following violation(s):

R 400.8125 Staff; volunteer; requirements

I recommend no change to the current license status.

Due to the violations, you must send us a corrective action plan by 02/23/2023. You can use our [corrective action plan](#) form or create your own. If you need help writing the corrective action plan, please contact me. If you do not send a corrective action plan, you may face disciplinary action. The corrective action plan must include the following:

- How compliance with each rule will be achieved.
- Who is directly responsible for implementing the corrective action for each violation.
- Specific time frames for each violation as to when the correction will be completed or implemented.

- How continuing compliance will be maintained once compliance is achieved.
- The signature of the responsible party and a date.

During this special investigation:	Yes	No
A rule or law violation was found and a serious injury or death occurred.	<input type="checkbox"/>	<input checked="" type="checkbox"/>
A rule or law violation was found and abuse and/or neglect of a child occurred.	<input type="checkbox"/>	<input checked="" type="checkbox"/>

This report and any related corrective action plans must be filed in your licensing notebook. This report and any related corrective action plans will be online for parents to review under the [Statewide Search for Licensed Child Care Centers and Homes](#).

Please review the enclosed documentation for accuracy and contact me with any questions. In the event that I am not available and you need to speak to someone immediately, please contact the local office at (517) 284-9730.

Sincerely,



Karen Woodman, Licensing Consultant
 Child Care Licensing Bureau
 611 W. Ottawa Street
 P.O. Box 30664
 Lansing, MI 48909
 (517) 285-9301

enclosure

**MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
CHILD CARE LICENSING BUREAU
SPECIAL INVESTIGATION REPORT**

I. IDENTIFYING INFORMATION

License #:	DC330018010
Investigation #:	2023D0109004
Complaint Receipt Date:	01/13/2023
Investigation Initiation Date:	01/18/2023
Report Due Date:	03/14/2023
Licensee Name:	Spartan Kid Care Inc
Licensee Address:	1730 Crescent Road East Lansing, MI 48823
Licensee Telephone #:	(517) 353-5154
Administrator:	Kaitlin Allen, Designee
Licensee Designee:	Kaitlin Allen, Designee
Name of Facility:	Spartan Child Development Center
Facility Address:	33 Crescent Road East Lansing, MI 48823-5705
Facility Telephone #:	(517) 353-5154
Original Issuance Date:	08/17/1981
License Status:	REGULAR
Effective Date:	02/19/2022
Expiration Date:	02/18/2024
Capacity:	140
Program Type:	CHILD CARE CENTER

II. ALLEGATION(S)

	Violation Established?
Child A (2-year-old female) was left unsupervised in the hallway.	Yes
Additional Findings	No

III. METHODOLOGY

01/13/2023	Special Investigation Intake 2023D0109004
01/18/2023	Special Investigation Initiated - On Site Arrival time: 3:25 PM; Departure time: 4:15 PM Interviewed: Kennedy Hariston, child care staff member Annie Sullivan, office coordinator
01/19/2023	Contact - Face to Face Arrival time: 10:08 AM; Departure time: 10:50 AM Interviewed: Isabella Riopelle, child care staff member Olivia Langley, child care staff member
01/19/2023	Contact - Telephone call made Telephone call to Child A's parent
02/02/2023	Exit conference: Kaitlin Allen, Program Director/Licensee Designee

ALLEGATION: Child A (2-year-old female) was left unsupervised in the hallway.

INVESTIGATION: On 1/12/2023, I received a telephone call from Kaitlin Allen, program director/licensee designee. She informed me of an incident that occurred regarding Child A being left unsupervised in the hallway. She also sent me the required incident report on 01/12/2023.

On 01/18/2023, I completed an unscheduled on-site inspection with consultant Samantha Struppa. Ms. Allen was not present at the center at the time of my on-site inspection. I spoke with Annie Sullivan, office manager.

Ms. Sullivan was in the front office on the day of the incident. Child care staff members Kennedy Hariston, Isabella Riopelle and Olivia Langley were present in the classroom the day of the incident with nine children. Ms. Langley is the lead caregiver in the classroom. Ms. Langley came to the office with Child A at 11:15 a.m. She told Ms. Sullivan that she went to the bathroom and when she came out, she found Child A in the hallway by herself. Ms. Sullivan said based on the video recording, Child A was unsupervised for about 2 minutes 45 seconds before Ms. Langley found her in the hallway. Neither Ms. Hariston nor Ms. Riopelle notified Ms. Sullivan that Child A was missing from the classroom. Ms. Sullivan called Kaitlin Allen, program director, to let her know what had happened. Ms. Allen asked Ms. Sullivan to review footage and get an idea of the exact timeline. Ms. Sullivan was instructed to communicate with each employee associated with incident and let them know there would be follow up steps. Ms. Sullivan spoke with Ms. Hariston and Ms. Riopelle individually and made them aware of the situation. Ms. Langley contacted Child A's parents by phone the same day. Typically, child care staff members will call the office if they need to step out of the classroom for a bathroom break or phone call. In this situation, child care staff members did not call down for coverage. Ms. Sullivan and Ms. Allen are currently in the process of formal disciplinary write ups with action plans and corrective action plans for the child care staff members in the classroom where the incident occurred.

During the on-site inspection I viewed the classroom and hallway area. The classroom has two doors. One door opens to the hallway and the interior door on the other side of the coat room leads to the classroom.

I viewed the video recording of the incident. The video does not have audio and the time is off by 1 hour, so it says p.m. but the time is actually a.m. There are two cameras that show the hallway area. The video shows child care staff member Ms. Langley leaving the classroom at 12:14:44 p.m. (real time 11:14:44 a.m.) At 12:15:01 p.m. (real time 11:15:01 a.m.), Child A leaves the classroom and is in the hallway. At 12:17:48 (real time 11:17:48 a.m.), Ms. Langley returns from the bathroom and sees Child A in the hallway. Based on the video footage, I concluded that Child A went into the hallway and was unsupervised for approximately 2 minutes and 47 seconds. The child care staff members inside the classroom were not aware that she was gone.

I interviewed Kennedy Hariston, child care staff member. She is a child care staff member in the toddler room and started working at the center on 01/06/23. She was present the day of the incident. Ms. Hariston was not aware of the incident until later in the day when Ms. Sullivan pulled her aside and told her that Child A, a 2-year-old, left the classroom at 11:14 a.m. when Ms. Langley went to use the bathroom. Child A was alone in the hallway for just over 2 minutes. Ms. Hariston was sitting on blue carpet reading to the children when the incident occurred and does not remember Child A walking out the door after Ms. Langley. When Ms. Langley said she was leaving to use the bathroom, Ms. Hariston thought Child A was in the corner reading books. She must have slipped through when it was closing because the children

can't open the door. The usual procedure is to call the office and have someone cover the classroom anytime a child care staff member has to leave the room. That day, no one called the office for coverage. Ms. Langley is the primary caregiver for Child A, and she called the parents right after it happened. Since the incident, anytime a child care staff member has to leave the room, child care staff members call the office and someone from the office comes to cover in the classroom.

I interviewed Isabella Riopelle, child care staff member. She is a child care staff member in the toddler classroom and started working at the center on 10/22/22. She was present the day of the incident. Ms. Riopelle was unaware of the incident until Ms. Sullivan told her as she was leaving at the end of the day. Ms. Sullivan said that one of the students followed Ms. Langley out of the classroom and was in the hallway by herself for just over 2 minutes. Ms. Riopelle remembers Ms. Langley telling her and Ms. Hariston she was leaving the room to go to the bathroom. Ms. Riopelle was in the play area with the children at the time of the incident and did not see Child A leave the room. She is not sure who contacted Child A's parents and she hasn't been back in the classroom since the incident. If a child care staff member has to leave the classroom, the normal procedure is to call down to the office for someone to come cover them.

I interviewed Olivia Langley, child care staff member. She is the lead caregiver in the toddler classroom and started working at the center on 07/12/2021. Ms. Langley had to use the bathroom and told Ms. Riopelle and Ms. Hariston that she was stepping out for a minute. She realizes now that she should have called down to the office for someone to cover her in the classroom, but she didn't. As she came out of the bathroom, she noticed the classroom door was open. She looked down the hallway and saw Child A in the hallway. Ms. Langley took Child A's hand and walked her down to the office. At the office, Ms. Langley talked to Ms. Sullivan and told her that Child A was in the hallway by herself when she came out of the bathroom. She walked Child A back down to the classroom. When she got to the classroom, Ms. Riopelle and Ms. Hariston did not notice that Child A was gone. Ms. Hariston was on the blue carpet and Ms. Riopelle was in the kitchen area with her back to the classroom. Ms. Langley called the parents to tell them that Child A followed her out of the classroom and was unattended in the hallway for a little more than 2 minutes. The parents thought it was "cute" that Child A wanted to follow her into the hallway. The normal classroom procedure is to call down to the office to get coverage if you have to leave the classroom, but Ms. Langley did not call to get coverage. There are two doors that lead into the classroom and one door is always shut. Ms. Sullivan informed Ms. Langley that Child A was in the hallway for 2 min 45 seconds.

On 01/19/23, I spoke with Child A's mother. She received a phone call from Ms. Langley on 1/12/23 telling her that Child A had followed her out into the hallway when she left the classroom. Ms. Langley found Child A in the hallway when she came out of the bathroom. Child A was in the hallway alone for a few minutes at most. Ms. Langley told her that Child A had been following her closely all day and must have gone to look for her. Child A's mother said that nothing like this has ever

happened before. Her only concern about the center is that it sometimes gets hectic around lunch time, at drop off and at pick up.

APPLICABLE RULE	
R 400.8125	Staff; volunteer; requirements.
	(1) All staff and volunteers shall provide appropriate care and supervision of children at all times.
ANALYSIS:	On 1/12/23, child care staff members, Ms. Langley, Ms. Riopelle and Ms. Hariston did not provide appropriate care and supervision of Child A. When Ms. Langley left the classroom, Child A followed her out of the classroom without Ms. Langley, Ms. Riopelle or Ms. Hariston's knowledge and was left unattended in the hallway for 2 minutes 47 seconds.
CONCLUSION:	<p>VIOLATION ESTABLISHED</p> <p>REPEAT VIOLATION ESTABLISHED SIR 2020D0219011 Dated 09/30/2020 Corrective Action Plan Dated 10/220/2020</p> <p>REPEAT VIOLATION ESTABLISHED SIR 2021D0108013 Dated 07/14/2021 Corrective Action Plan Dated 07/19/2021</p> <p>REPEAT VIOLATION ESTABLISHED SIR 2021D0108014 Dated 08/09/2021 Corrective Action Plan Dated 08/23/2021</p>

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend no change to the status of the license.

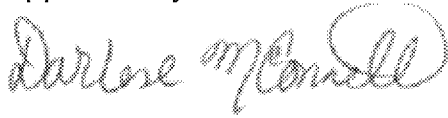


02/03/2023

Karen Woodman
Licensing Consultant

Date

Approved By:



02/03/2023

Darlese McConnell
Area Manager

Date