GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

AMENDED REPORT

July 31, 2023

Toby Berry
Community Action Agency
1214 Greenwood Ave
Jackson, MI 49203

RE: License #: DC380018517
Investigation #: 2023D0197015
Lyle Torrant Center Head Start

Dear Ms. Berry:

I conducted a special investigation because the child care licensing bureau received information regarding your facility that related to licensing rules or law. This report contains an amendment based on a typographical error found on page 12. The conclusion for rule 400.8125(1) Staff; volunteer; requirements indicated violation not established and was amended to violation established.

The information regarding the special investigation was related to the following:

R400.8125(1): Staff; volunteer; requirements.

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

- I interviewed an administrator, the program director, child care staff members, witnesses, and parents.
- I completed on-site inspections on the following dates: 4/19/23 and 4/20/23.

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

R400.8125(1): Staff; volunteer; requirements.
R400.8112(1); Comprehensive background check; fingerprinting.

I recommend no change to the current license status.

Due to the violations, you must send us a corrective action plan by 08/20/2023. You can use our corrective action plan form or create your own.
5
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.	☒	☐
A rule or law violation was found and abuse and/or neglect of a child occurred.	☐	☒

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,

Jenny Camburn Brundage

Jenny L. Camburn Brundage, Licensing Consultant
Child Care Licensing Bureau
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 262-9717

enclosure

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

I. IDENTIFYING INFORMATION

License #:	DC380018517
Investigation #:	2023D0197015
Complaint Receipt Date:	04/13/2023
Investigation Initiation Date:	04/13/2023
Report Due Date:	06/12/2023
Licensee Name:	Community Action Agency
Licensee Address:	1214 Greenwood Ave Jackson, MI 49203
Licensee Telephone #:	(517) 784-4800
Administrator:	Toby Berry, Designee
Licensee Designee:	Toby Berry, Designee
Name of Facility:	Lyle Torrant Center Head Start
Facility Address:	1175 W. Parnall Road Jackson, MI 49201
Facility Telephone #:	(517) 784-1171
Original Issuance Date:	11/04/1991
License Status:	REGULAR
Effective Date:	11/13/2022
Expiration Date:	11/12/2024
Capacity:	50
Program Type:	CHILD CARE CENTER

II. ALLEGATION(S)

	Violation Established?
On 4/12/2023, Child A (age 5 years, male) was doing a fire drill. He got his finger caught in the door. He sustained a laceration that required stitches and a surgical pin on the tip of his finger. The center did not call 911.	Yes
Additional Findings	Yes

III. METHODOLOGY

04/13/2023	Special Investigation Intake 2023D0197015
04/13/2023	Contact - Telephone call made Contact with Administrator 1.
04/13/2023	Special Investigation Initiated - Telephone Interview with Child A's Mother.
04/13/2023	Contact - Telephone call made Interview with Child A's Father.
04/13/2023	Contact - Telephone call made Call to and from Officer Regnier, Blackman Township Police.
04/19/2023	Inspection Completed On-site from approximately 8:30 - 11:45am. Face to face contact with Ms. Salyer, program director; Child Care Staff Member 1, Child Care Staff Member 2, Witness 1, and Witness 3.
04/20/2023	Inspection Completed On-site from approximately 8:35-9:50am Face to face contact with Ms. Salyer, Child Care Staff Member 1, Child Care Staff Member 2, Witness 4, and Witness 5.
07/05/2023	Contact - Telephone call made Interview with Administration 1.
07/05/2023	Contact - Telephone call made Interview with Witness 2.
07/05/2023	Attempted Exit Conference with licensee designee. Exit conference completed with Administrator 1.

07/05/2023	Inspection Completed-BCAL Sub. Compliance

ALLEGATION: On 4/12/2023, Child A (age 5 years, male) was doing a fire drill. He got his finger caught in the door. He sustained a laceration that required stitches and a surgical pin on the tip of his finger. The center did not call 911.

INVESTIGATION: I spoke with Administrator 1. She stated that on 4/12/23, Child A's finger was severely injured while in care. Someone not affiliated with the center pulled the fire alarm, causing concern that there was a fire in the building. Child A was attending speech therapy at the time. Child A was in the process of being evacuated when he got his finger shut in the door. There were two trained medical professionals on site that treated Child A until his parent arrived to take him to the hospital. Administrator 1 stated that she spoke with the Child Care Staff Members (CCSMs) later that day. They told her that his finger was bloody, and it was difficult to view the extend of the injury. They knew Child A had a deep cut that needed medical attention, but they did not realize how deep the was at the time. Child A was taken to the hospital. The tip of his finger was almost severed. A stint was placed in his finger to attempt to keep the fingertip in place. At the time of the injury, there were 16 children ages 3 years and older in the room. The CCSMs in the room at the time included the program director Ms. Salyer and CCSM1.

I interviewed Child A's Mother. She stated that Child Care Staff Member (CCSM) 2 called her frantic on 4/12/23 at 1:23 p.m. notifying her of Child A's injury. CCSM 2 told her that there was an incident, that he had a severe injury to the tip of this finger, that Child A needed to go to the emergency room now. Child A's Mother stated that she called Child A's Father and he rushed to get Child A and take him to the hospital. When Child A was examined at the hospital, the tip of his middle finger on the right hand was almost detached. There was concern that he might lose the tip of his finger. Child A had surgery and a surgical pin was placed in his finger. Child A will require additional follow up medical appointments. Child A's Mother is concerned that the center did not call 911. She does not necessarily believe that an ambulance was needed, but the telephone call to 911 would have checked to see if it was safe to transport him in a vehicle, as well as warn the hospital that they were on the way. Child A later told his mother that he was in speech class and there was a fire drill. Child A said the door shut on his finger. Child A's Mother is concerned that no one held the door for him as the center has heavy steel doors. Child A's Mother stated that prior to this incident, she did not have previous concerns regarding the center's care or supervision of Child A.

I interviewed Child A's Father. He stated that he received a call from Child A's Mother on 4/12/23 at 1:24 p.m. Child A's Mother was crying and said that Child A needed to go the emergency room. Child A's Father stated that it took him approximately 25 minutes to get to the center. Child A was outside being held in the play area. He was screaming. The center staff tried to speak with Child A's Father,

but he said that now was not the time. Child A was "covered" in blood. His finger was bandaged by two registered nurses who were on site at the center. Child A's Father was able to get Child A to calm down. Child A told him that the door was shut on this finger. Child A said that no one held the door open. Child A's Father took Child A to the hospital. On the way to the hospital, he spoke on the phone with someone from the center who told him what happened; but it seemed as though this person was asking for reassurance from someone else which concerned him. When they got to the hospital they were taken straight back to be treated. The bandage was removed, and the tip of his finger was "barely hanging on", and the bone was exposed. The triage nurse asked him why an ambulance was not called. Child A required surgery. Child A's Father stated that he spoke with Child A again. Child A told him that the fire alarm went off and no one held the door. Child A told him that it occurred during speech therapy and rest time. Child A's Father stated that he wants to know what happened, and why no one called the ambulance. He was told by someone at the center that there were nurses on site at the time, and that since the alarm was pulled that an ambulance would have arrived on site. Child A's Father believes it should have been verified that an ambulance was in route. He would have preferred that they called an ambulance.

I interviewed Officer Regnier from Blackman township police department. He stated that Child A's Father contacted the police department. Child A's Father was concerned after he was questioned in the emergency room about the overall response time, which had been immediate on the part of his father. Officer Regnier stated that no further law enforcement intervention is needed. He stated that typically, if a building has a fire drill, an ambulance will not be sent. If there was thought it was an actual fire, an ambulance would arrive on scene.

I interviewed Ms. Salyer, program director. She was working in Child A's room on 4/12/23 when the fire alarm sounded during rest time. At the time, Child A and Child B were attending speech therapy alone with Witness 1 in a room two doors down the hallway. The center staff thought that it was a real fire as this was not a scheduled drill. Ms. Salyer, CCSM 1, Witness 2 and Witness 3 immediately began working to get the children to the exit door in the room that leads directly outside. The room was still dark as they did not take time to put on the lights to due moving quickly to get the children out of the building. The alarm was "very loud" with "bright blinking" lights. As the children were waking up, many of them started crying and screaming. She stated that this was a "very" hectic time.

Ms. Salyer stated that right after the alarm sounded, Witness 1 returned to the room with Child A and Child B. They were still near the door when Child B started screaming. Suddenly, Child A also started screaming which was not expected behavior for him. She looked over, Child A held up his hand and it was bleeding. Witness 1 and Child Care Staff Member 1 immediately took Child A to the sink quickly to rinse the injury and give him a towel as she continued with the evacuation and took the children outside. Child A evacuated with the rest of the class. At this same time, Child B tried to run away from the group. Child B was followed and

brought back. Child A was handed to Witness 2 while CCSM 1 assisted caring for the rest of the children. CCSM 2 also joined them to assist the room. Child A was taken to a picnic table separate from the other children with CCSM 2, Witness 2, Witness 4, and Witness 5 while his mother was contacted. Witness 4 and Witness 5 are registered nurses. They were able to calm Child A down. It also took up to 10 minutes for the CCSMs to learn that there was not an actual fire in the building, but that a someone not affiliated with the center pulled the fire alarm. Child A's Father arrived within 20 minutes and took Child A to the hospital. I asked Ms. Salyer about the decision to not call 911. She stated that the school had two nurses who responded quickly and provided Child A with medical treatment on site. The two nurses who provided his immediate medical care did not verbalize that 911 needed to be called, as they knew that Child A's Father on the way to the center. She did not observe the injury as his finger was already covered, but she was told that it was a deep cut.

Ms. Salyer stated that although no one directly observed the injury occur, she is guessing that Child A may have got scared by all the noise in the room, especially when Child B stated screaming next to him. She guesses that Child A may have taken a step backwards and rested his hand in the door jam as the door closed automatically. Ms. Salyer stated that she "loves" Child A and that she feels terrible that this accident occurred. She again stressed that this situation was urgent with the fire alarm, as well as upsetting for many of the children that have sound sensitivities. Ms. Salyer stated that all the CCSMs strive to keep the children safe. She believes this accident would not have occurred if there had not been the stress of the fire alarm happening at the same time.

I interviewed CCSM 1. She stated that on 4/12/23, she was working in Child A's room. The children were engaged in rest time with the room dark. Child A and Child B were attending speech therapy services when an unplanned fire alarm sounded. As such, they thought that it might be an actual fire in the building. It was a hectic and urgent situation as they rushed to wake up the children to evacuate. Some of the children were crying and screaming. During this time, she was in the room with Ms. Salyer, Witness 2 and Witness 3.

CCSM 1 stated that she observed Witness 1 come back into the room right after the alarm sounded. Child A and Child B had been alone with her receiving speech therapy in another room. Witness 1 was holding Child A and Child B's hands. She observed Child B cover her ears and start screaming. Witness 1 turned her attention to Child B. CCSM 1 did not see Child A get injured but assumes that he stepped back and put his hand against the door jam as the automatic door closed. She heard Child A scream, which is unusual for him. Witness 1 yelled for her, but it was hard to hear her with the fire alarm sounding. CCSM 1 saw blood on his hand. She stated that it was hard to see the injury as it was still dark in the room, and it was bleeding. The other children continued to be upset, including one child attempting to run away from group inside the room. CCSM 1 stated that she took Child A to the sink to rinse his finger under the water and she placed a towel around his finger. She picked him

up and carried him out of the building with the rest of the evacuating children. Child B then decided to run away from the group while outside, but she was supervised and brought back to the group. CCSM 1 handed Child A to Witness 2 so that she could assist with keeping the other children together. She described the situation as "total chaos" with so many urgent things happening all at once. CCSM 2 also joined the classroom to help. Once outside, Child A was moved away from the other children, and he received immediate professional medical treatment from two on-site nurses. Child A's Mother was also contacted quickly once they evacuated. CCSM 1 stayed with the classroom alongside Witness 3. Witness 1, CCSM 2, Ms. Salyer, Witness 4 and Witness 5 stayed with Child A. CCSM 2 spoke with Child A's Mother the first time. CCSM 1 spoke with her about a minute later saying that Child A's Father was on his way. The two nurses stayed with Child A until his father arrived.

I asked CCSM 1 about the decision to not call 911. CCSM 1 stated that in the moment, it was a judgement call. When she looked at Child A's finger at the sink, it looked like a deep cut. His finger appeared intact, and she did not observe any bone. She did not touch it or try to move the fingertip. She rinsed the injury quickly, put a towel over it. Once outside, the nurses began providing medical treatment, the bleeding stopped, and she knew that his father was on the way. I explained to CCSM 2 how Child A's fingertip was almost detached. CCSM 1 stated that she did not observe that as his finger looked intact when she looked at it. She thought that his finger had a deep cut below his nail moving upward on his fingertip. CCSM 1 said that she would have called 911 if the nurses were not on site to provide the emergency medical treatment, or she had known how severe the injury was to his finger. CCSM 1 believes that the children receive good care and supervision while in care, and that this was an unfortunate accident. She does not believe that Child A would have been injured if the alarm was not going off at the same time. CCSM 1 stated that normally when children come into the room, they do not stay by the automatically closing door. Only adults open the doors.

I interviewed CCSM 2. She stated on 4/12/23, she was assisting as an extra child care staff member in another room when the unplanned fire alarm sounded. She stated that it was a hectic and scary time for the children as it occurred during rest time. She was assisting the children to evacuate in another room when CCSM 1 said that they needed help. She observed Witness 2 caring Child A cradled in her arms. She looked quickly at his finger which had a towel around it. CCSM 1 told her that Child A's finger was closed in the room door. CCSM 2 did not observe the injury in detail, but she was told by CCSM 1 that they though it was a deep cut that would need stiches at the hospital. CCSM 2 immediately called Child A's Mother to begin the communication with her. Child A's Mother was upset and got off the phone. She called the center back quickly saying that Child A's Father was coming to get him. CCSM 2 then walked up to Child A who was already being treated by Witness 4 and Witness 5. Witness 4 and Witness 5 told her it was a deep cut, saying the injury was more serious than they thought it was originally. Child A was crying. He has a speech delay, but he said that it hurt. Witness 4 and Witness 5 made the injury more stable by bandaging the injury, as well as using a pressure bandage to be sure the

bleeding was stopped. CCSM 2 kept Child A's attention on her to distract him. As such, she did not observe the full extent of the injury as it was already covered. Child A was able to calm down. Child A's Father arrived and took him to the hospital.

CCSM 2 said 911 was not called because when she initially observed Child A's finger quickly, it had a towel on it. The finger was bleeding and appeared intact as the tip was still in place. She did not observe any bone. She knew it was a deep cut, and that it would need stiches. She did not try to move his finger to look further as she did not want to cause any damage. She did not realize that it was almost severed, saying that it looked "sliced from below his nail rounding up to the back of his finger." I explained to CCSM 2 how Child A's fingertip was almost detached. She again stated that is not what she observed when she quickly looked at it. CCSM 2 stated that in addition, Child A was already receiving medical treatment by two trained medical professionals, and the bleeding had stopped. Child A also calmed down. The two medical professionals did not indicate that a call to 911 was needed. They also knew that Child A's Father was coming to pick up Child A. She also thought that ambulance might have already been dispatched to the building due to the fire alarm being pulled as it was not thought to be a drill.

CCSM 2 stated that she spoke briefly with Child A's Father when he arrived, telling him that the injury was deeper than she first thought when she called his mother and that Child A needed to go straight to the emergency room. CCSM 2 stated that if she knew Child A's fingertip was almost detached or if he did not receive professional medical care from two registered nurses on site, she believes that she would have called 911. CCSM 2 stated that the CCSMs in the room provide the children with good care and supervision. The children's safety is taken seriously. She stated that Child A is a "sweet child", and they like having him attend the program. She hopes that he returns to the center. CCSM 2 stated that as the door entering the room is self-closing, the children do not play around the door. CCSM 2 also notified the center's off-site education supervisor.

I interviewed Witness 1. She was visibly upset, saying that she would never want to see any child be injured. She stressed that this was an unfortunate accident. On 4/12/23, she was working alone providing speech therapy services to Child A and Child B. She was getting ready to return them to the room when the unplanned fire alarm went off. The emergency lights started flashing and the alarm was "very loud." She took the children by the hands. Child B was holding her left hand. Child A was holding her right hand. The walked quickly to the room a few doors down to keep the class together while evacuating. There was no smoke or sign of fire. The room was dark, the emergency lights were blinking, the alarm was loud, and the CCSMs in the room were working to wake up the children to evacuate. She walked Child A and Child B into the room and continued to hold their hands as they cleared the room door. She stated that they took several steps inside the door, so she did not think they were close to the door. Child B started screaming, she covered her ears, and was crying. Witness 1 directed her attention toward Child B. She continued to hold Child A's hand. Child A then started crying, but she thought it was because Child B

started crying first. She then realized that Child A injured his finger. Witness 1 stated that she did not see the injury occur. She guessed that Child A must have stepped backwards toward the door and put his hand out behind him because Child B started screaming. Witness 1 stated that she saw his finger in the door jam. The door had not completely shut on it, it was not amputated, and she saw blood. Child A was taken quickly to the sink by CCSM 1. Witness 1 ran to the door and waved for CCSM 2 to come inside to assist in the room. The children, including Child A, were quickly evacuated. Child A's Mother was contacted by CCSM 2 from inside CCSM 2's office immediately. Witness 1 stated that as they did not see or smell smoke, they felt confident for CCSM 2 to make the phone call quickly from inside the building before going outside where the children and other CCSMs were located. The phone call was "quick." Witness 1 then ran to get the help of Witness 4 and Witness 5. When she got outside, Child A was being held by Witness 2 near the rest of his class. He had a towel on his hand. He was then separated from the group. Witness 4 and Witness 5 arrived quickly to provide medical care. Witness 1 stated that she stayed with Child A, although she did not get a detailed view of his injury. Witness 4 and Witness 5 did not feel that a call to 911 was needed, but they felt that his injury needed to be medically addressed at the emergency room. Child A's Father arrived to pick up Child A about 15 minutes later. Witness 1 stated that Child A is sensitive, a good student, and that she "loves" him. She "always" has the children's best interest and safety at heart. Witness 1 stressed that this was a "compete accident." Witness 1 believes that if there was not fear of a possible fire in the building, this accident would not have happened. She believes that the transition of Child A and Child B would have been calm.

I interviewed Witness 2. She works daily in the room to support children with individualized service plans. She stated that on 4/12/23, the room was dark during rest time. The fire alarm unexpectedly went off causing a hectic time. She was rushing to help wake up the children to evacuate. Witness 1 came into the room with Child A and Child B. She suddenly heard a scream. She did not see Child A get injured but guesses that he might have stepped backwards accidently placing his hands in the door jam. Witness 2 saw CCSM 1 put Child A's finger under the sink. She was standing several feet away but noticed there was a lot of blood. She did not get a detailed view of the injury at this time as they quickly put a towel on his finger. She did not see the tip of his finger detached or the bone exposed. CCSM 1 carried Child A to evacuate with building. Witness 2 asked CCSM 1 if she needed help with Child A so that CCSM 1 could continue to assist with the other children. CCSM 1 agrees, and Witness 2 held Child A, who calmed down for a few minutes. The bleeding also slowed down. She did not take the towel off as she wanted to keep putting pressure on the injury. She carried Child A away from the group near the outdoor play area where the nurse met her to begin providing medical treatment. CCSM 2 and Witness 1 were also near the nurses. Witness 2 stated that when towel was removed from Child A's hand, she observed that the injury was worse than they originally thought. Originally, she thought that it was a deep cut that would need stitches. However, when she looked down, the tip of his finger was barely attached. She tried to keep Child A's attention toward her to keep him from looking at it.

CCSM 2 stated that they got the bleeding to stop by putting pressure on it, but it may have started again. Child A's Father arrived about five minutes after they finished bandaging his finger. The two medical professionals treating Child A did not indicate that they needed to call 911. Witness 2 stated that this was an accident. She believes that this would not have happened it if were not for added stress of the unplanned fire alarm. Witness 2 stated that the CCSMs in the room provide the children with good care and supervision. The children do not play near the door.

I interviewed Witness 3. She works daily in the room to support children with individualized service plans. She stated that on 4/12/23, the room was dark during rest time. The fire alarm unexpectedly went off causing a hectic time. The alarm was loud and several of the children were upset. Several of the children were crying and screaming. She observed Witness 1 walk into the room with Child A and Child B. Child B started screaming being upset with the loud fire alarm sound. Witness 3 went back to trying to wake up the children. Child A started screaming, which is not usual as he is normally quiet. Witness 1 said that she needed help, but the alarm was loud, and the lights were flashing making it hard to know what exactly what was happening. She saw Child A taken to the sink. Witness 3 did not observe Child A's finger, as she was assisting with the other children in the room. Once outside, she remained with the rest of the children as Child A received medical care from Witness 4 and Witness 5. Witness 3 stated that she works in the room daily. She believes that the children receive good care and supervision. The children do not stay or play by the door, saying that safety is a priority in the room.

I interviewed Witness 4 and Witness 5 together. Both are Bachelor Level Registered nurses that work inside the school building. They both provided medical care to Child A after he was injured. Witness 4 said that Witness 1 ran to get them and asked for help because of Child A's injury. Witness 4 left first while Witness 5 stated that she did quick internet refresher which stressed the need to stop the bleeding and keep the finger intact. Witness 4 stated that when she arrived, Child A was holding a towel and his finger was not bleeding anymore. Witness 4 called Witness 5 and asked her to bring bandages and an ice pack. Witness 5 arrived no more than 10 minutes later. Witness 4 kept the towel on his finger until Witness 5 arrived with the bandages. Witness 4 told Witness 5 that the cut was "bad." They removed the towel with no further bleeding, saying that there was "not a lot of blood." The bleeding remained stopped while they wrapped his finger in a bandage and stretch gauze. They were careful with how they wrapped it so that the tip of his finger would not fall off. They were told that Child A's Father coming to pick up Child A. Child A's Father arrived as they were finishing wrapping his injury, about five minutes after Witness 5 arrived to help. They offered to give Child A's Father ice in case the tip of his finger fell off on the way to the hospital. I asked Witness 4 and Witness 5 their professional medical opinion about calling 911. They did not believe a call to 911 was warranted as the bleeding had stopped, Child A was conscious, talking, and a parent was in transit to pick him up to take him to the hospital. They stated that if his parent was not able to be reached, then yes, they would have called 911. In addition, if the bleeding had not stopped or if the finger has been completely

severed, they would have called 911. Regarding the medical care that he received, they do not believe that the paramedics would have provided to Child A with additional first aid beyond what had already been provided to him. They stated that although their training is different than what a paramedic receives, they have an overall higher level of medical training based on their degree.

I viewed the area where Child A was injured. The injury occurred at the door of the room that leads into the building hallway. The wooden door has an automatic self-closing mechanism. The door is surrounded by a metal frame.

I observed inside the room. There were three CCSMs and two witnesses with the children. The children received good care and supervision. I did not see any of the children near the door.

In addition, I provided the center with technical assistance and consultation regarding the center's written emergency plans. I asked Ms. Salyer about the center's written emergency plans for responding to a serious accident or injury. Ms. Salyer was able to locate the four different written plans. CCSM 1 and CCSM 2 were both aware that the center has written emergency procedures; however, they also indicated that the center has several different written plans. Ms. Salyer, CCSM 1, and CCSM 2 all stated that they have been trained the center's emergency plans at the beginning of the year and at least one more time during the year. Upon reviewing the emergency plans with the CCSMs, they indicated that they followed the school's emergency plans as directed.

I observed the center's written emergency plans to include:

The parent handbook plan indicated that a staff member trained in first aid will handle all injuries. Minor injuries (bumps, scrapes, bruises) will be reported to parents by use of our Student Injury Repot form, which will be sent home with your child. If your child is involved in a medical or dental emergency, our staff are trained to follow the steps in our emergency plan or action. A decision will be made if the accident/illness requires an ambulance to transport your child for emergency medical care, or if parents/staff are able to transport your child. You will be contacted immediately. If you cannot be reached, we will call the next person designated on the Emergency Release form.

The room contained three different written emergency procedures. Two of the plans were located inside the room and one plan was located outside the room.

1) The room contained a yellow paper titled Emergency Procedures. The yellow paper indicates that for a Serious Accident or Illness, that there needs to be a completed accident report and forward to supervisor. The teacher/teacher assistant will care for the injured/sick child and remain with them. The teacher/teacher assistant will notify the supervisor as soon as possible and follow procedures for reportable incidents.

2) The room also contained a white paper entitled Staff Guidelines. In small print under the title is indicates that "Classrooms in buildings not owned by CAA will follow the protocol of that building." On the white paper under "Injury/Medical Emergency", it indicated that: If first aid is sufficient, have trained first aid person check out the injured person. They are to notify family or parent/guardian and if they want to pick up client, student, or staff. They must complete an accident form and give to Human Resources. If First Aid is not sufficient, it indicates to not move the person and call 911. They are to send a staff person to street to direct emergency vehicle and handle traffic, and to notify crisis response team member and staff in charge of command notifications. Transportation would be my ambulance and NOT an agency vehicle. Two adults would accompany the child to the hospital with at least in a separate vehicle. They would remain with victim(s) until responsible adult arrives at hospital. An incident report would be completed. I noted that this center is not located inside a building owned by the CAA. As such, they would need to follow the building protocol.
3) Outside the room was the Lyle Torrent School's written plans. According to the school's plan, for Medical Emergency/Muti-Casualties there are responsibilities for both staff and administrators. The staff's responsibilities include to evaluate the accident scene, isolate, and secure the area. They are to direct any unaffected persons to a safe and secured area and notify the administrator in charge as soon as possible. They were also to notify Witness 4 and Witness 5. If the scene is safe, they are to proceed to the victim and access the severity of the injury, stabilize the victim, and administer first aid. They staff are also to assist with emergency responders. If the scene is not safe, they are to wait for emergency medical services. The administrator responsibilities include to call 911, notify Witness 4 and Witness 5, and call Adult 1 or Adult 2. The administrator will report to the scene, secure, and isolate the area while having a staff trained in first aid/CPR respond to the area to assist. The administrator will assign an individual to meet and escort the emergency medical responders, provide police/emergency medical services with emergency information, and notify the parent/guardian. They will accompany the student/staff to the hospital if the parent/guardian cannot be there.

I spoke with Administrator 1. She works as an administrator for the center. Administrator 1 verified that that the CCSMs followed the school's written emergency, as the center is located inside a building not owned by the center. Administrator 1 stated that she notified Adult 1 and Adult 2 who are administrators for the Intermediate School District, as that was required from the school's plan. She stated that the CCSMs are training in general emergency response at least twice a year. They are also trained in the school's emergency response if applicable based on the center's location. The CCSMs also sign a statement that they have reviewed the plans.

I provided the center staff, including Administrator 1 with technical assistance and consultation, specifically, that having more than one written plan could lead to confusion for CCSMs. I suggested having only one plan in place.

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 4/12/23, Child A sustained an accidental injury while attending the center. Child A was not moved far enough from the self-closing door to the room, which caused injury to his finger.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION: Based on interviews, Witness 1 was alone with Child A and Child B not under the direct supervision of CCSMs. Witness 1 stated that although she has completed a criminal background check to work in the school, that she has not yet completed a separate background check to work unsupervised in a licensed child care facility. I reviewed the center's comprehensive background check system and verified that Witness 1 had not yet completed a background check specific to working in a child care center. Witness 1 later completed the background check the next day and was deemed eligible.

I interviewed Administrator 1. She stated that moving forward, individuals providing specialized services to children will either work directly in the room or they will have parent permission to sign the children out of care in order to work with children independently. The children will be signed back into care once the specialized services are completed.

APPLICABLE RULE	
R 400.8112	**Comprehensive background check; fingerprinting.**
	(1) Pursuant to section 5n of the act, MCL 722.115n, before an individual has unsupervised contact with children, the department shall determine the individual's eligibility to be any of the following: **(a) A licensee.**

	(b) A licensee designee. **(c) A child care staff member.** **(d) A child care aide.** **(e) An unsupervised volunteer.**
ANALYSIS:	On 4/12/23, Witness 1 was alone with Child A and Child B not under the direct supervision of CCSMs. Witness 1 had not yet completed a criminal background check to work unsupervised in a licensed child care facility.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

Jenny L. Camburn Brundage 7/26/23

Jenny L. Camburn Brundage Date
Licensing Consultant

Approved By:

Darlese McConnell 07/31/2023

Darlese McConnell Date
Area Manager