State of Michigan
DEPARTMENT OF HUMAN SERVICES
BUREAU OF CHILDREN AND ADULT LICENSING

RICK SNYDER
GOVERNOR

MAURA D. CORRIGAN
DIRECTOR

May 22, 2013

Tanya Zoro
Childtime Child Care Inc
Suite 300
21333 Haggerty Road
Novi, MI 48375

RE: Lic./Reg. #: DC500294563
Investigation #: 2013D0351008
Childtime Learning Center #0632

Dear Ms. Zoro:

Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and 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.

If you desire technical assistance in addressing these issues, please feel free to contact me. In any event, the corrective action plan is due within 15 days. Failure to submit an acceptable corrective action plan will result in disciplinary action.

Please review the enclosed documentation for accuracy and feel free to contact me with any questions. In the event that I am not available and you need to speak to someone immediately, please feel free to contact the local office at (248) 975-5053.

Per MCL 722.113g, this report and any related corrective action plans must be filed in your licensing notebook.

Sincerely,

Christine Noel

Christine Noel, Licensing Consultant
Bureau of Children and Adult Licensing
51111 Woodward Ave, Suite 4B
Pontiac, MI 48342
(586) 256-1968

Enclosure

MICHIGAN DEPARTMENT OF HUMAN SERVICES
BUREAU OF CHILDREN AND ADULT LICENSING
SPECIAL INVESTIGATION REPORT

I. IDENTIFYING INFORMATION

License #:	DC500294563
Investigation #:	2013D0351008
Complaint Receipt Date:	04/02/2013
Investigation Initiation Date:	04/03/2013
Report Due Date:	06/01/2013
Licensee Name:	Childtime Child Care Inc
Licensee Address:	Suite 300 21333 Haggerty Road Novi, MI 48375
Licensee Telephone #:	(248) 697-9106
Administrator:	Tanya Zoro, Designee
Licensee Designee:	Tanya Zoro, Designee
Name of Facility:	Childtime Learning Center #0632
Facility Address:	31480 23 Mile Road Chesterfield Twp, MI 48047
Facility Telephone #:	(586) 598-1700
Original Issuance Date:	06/05/2008
License Status:	REGULAR
Effective Date:	02/04/2013
Expiration Date:	02/03/2015
Capacity:	159
Program Type:	CHILD CARE CENTER

II. ALLEGATION(S)

On 03/26/2013, Child A (4 year old male) had an allergic reaction after treatment for an injury to his finger; he was sweating, pale, and blue around the nose and mouth. The center contacted 911 to have medical first responders come to the center. The center did not report this incident to the department until 04/01/2013.

III. METHODOLOGY

04/02/2013	Special Investigation Intake 2013D0351008
04/03/2013	Contact - Telephone call made To Child A's Mother- contact actually took place on 04/01/2013 while waiting for the incident report
04/03/2013	Special Investigation Initiated - On Site from 11:15 AM to 12:30 PM- Interviewed: Program Director Rebecca Hirmaz Assistant Caregiver Julie Wysocki Assistant Caregiver Rebekah Armstrong
05/01/2013	Exit Conference with Rebecca Hirmaz
05/03/2013	Contact - Telephone call received from District Manager Tanya Zoro
05/20/2013	Corrective Action Plan Requested and Due on 06/10/2013

ALLEGATION: On 03/26/2013, Child A (4 year old male) had an allergic reaction after treatment for an injury to his finger; he was sweating, pale, and blue around the nose and mouth. The center contacted 911 to have medical first responders come to the center. The center did not report this incident to the department until 04/01/2013.

INVESTIGATION: On 03/28/2013, I received an email from Program Director Rebecca Hirmaz, which stated, “Can you please contact me when you get a chance today”. I was on leave on 03/28/2013 and contacted Ms. Hirmaz by telephone on 03/29/2013. I was told that she was not working on this date. I then responded to Ms. Hirmaz’s email and requested that she contact me when she was back in the office.

Ms. Hirmaz contacted me via telephone on 04/01/2013 at which time she informed me that there had been an incident at the center on 03/26/2013. Ms. Hirmaz stated

that on Tuesday 03/26/2013 at11:00 am, Assistant Caregiver Julie Wysocki came running to get her to go check on Child A. Ms. Wysocki stated that Child A was playing with blocks and cut his knuckle. She put a band aid on it and then remembered that Child A is allergic to purple dye and immediately took the band aid off. Child A then started wheezing, turning purple, and becoming weak. Ms. Hirmaz then took him to her office, where he continued to be weak.

During this time, Child A was talking; however, he was scared and said he wanted to go home. Ms. Hirmaz then called 911, while Assistant Director Laura Anderson called Child A's Mother, and Ms. Wysocki tended to Child A. Ms. Hirmaz stated that Ms. Wysocki flipped Child A onto his side to help with blood flow to see if his color would come back. This seemed to work because Child A began talking more and was not as scared.

Child A's Mother and the ambulance then arrived, and Child A was fine. Child A's Mother stated she had been giving Child A things with purple dyes with no problem. Ms. Hirmaz stated that Child A's Mother took him to his pediatrician that night and the pediatrician said that Child A probably went into shock. Later that same day, 03/26/2013, Child A's Mother brought Child A back to the center for an event they were having with the Easter Bunny, and he was fine

I requested that Ms. Hirmaz complete an incident report (BCAL-4605) and fax it to me. Ms. Hirmaz completed the incident report and faxed it to me on 04/01/2013.

I spoke with Child A's Mother on 04/01/2013. She stated that on Tuesday 03/26/2013, Child A said a wooden block fell on his finger. Child A said the blocks were on the end of the table and when another child bumped the table, the block fell on his finger. She stated that this is consistent with the explanation that the center told her about the injury

Child A's Mother stated that Child A did not cry when he hurt his finger because he gets embarrassed, so he held it and made it worse. She stated that Child A has asthma, which may have contributed to him looking blue in the face. When Ms. Anderson called Child A's Mother and said that they were contacting 911, she told them to go ahead and do so if they felt they needed to call 911. Child A was to the point where he was either going to faint or pass out. She felt that the center handled the situation great.

When she arrived, the emergency medical technicians (EMT's) were there, who said that Child A's reaction was to pain, not necessarily to the purple band aid. At that point, Child A's vitals were fine. Child A's Mother took Child A to the pediatrician at 6:00 PM that evening, who said the same thing as the EMT and that this had nothing to do with the purple band aid, more of his reaction. Child A's Mother has no concerns with regards to supervision and feels everything was handled appropriately. Child A has returned to the center.

I completed an unannounced, on-site inspection on 04/03/2013. I spoke with Program Director Rebecca Hirmaz. We reviewed the sequence of events that she told me during our 04/01/2013 telephone conversation. She stated that Child A's Mother told them that when Child A was a baby she gave him purple Tylenol and he had a reaction to it. However, Child A is now four years old and she has been giving him purple drinks, etc., and he has not had any reaction.

I reviewed the attendance record for 03/26/2013, which reflected that there were 15 children present at the time of the incident and two caregivers, Julie Wysocki and Rebekah Armstrong. The classroom was in compliance with ratio of one caregiver to ten children. Child A was signed out by his mother at 11:30 AM.
I observed the classroom and the blocks that Child A was playing with when he cut his finger. The blocks were the normal sized, wooden blocks and did not appear to have sharp edges.

I reviewed Child A's Child Information Card that indicated that he was allergic to purple dye. Child A was enrolled in the center on 04/03/2012.

I then spoke with Julie Wysocki. She stated the children were doing an art project, and Child A had just finished his, so we went over to play with the blocks. Rebekah Armstrong was also in the room and was at the sink. Child A then came up to Ms. Armstrong, whispered something to her and then showed her his finger and told her that a block hit him. Ms. Armstrong cleaned it up, and Ms. Wysocki put a band aid on his finger.

Ms. Wysocki went back to the art table, and when she turned around a few moments later Child A was pale. She instructed Ms. Armstrong to put Child A over her knee to help with blood flow; however, Child A was resistant and his coloring was not coming back. Ms. Wysocki then remembered that Child A was allergic to purple dye and the band aid was purple, so she took the band aid off. She then checked the paint that they were using to be sure it was not purple, and it was only yellow.

Ms. Wysocki then went to get Ms. Hirmaz and then went back to the front office with Child A. Ms. Hirmaz was on the telephone with 911 when Ms. Wysocki put Child A over her lap and his color started to come back. Ms. Wysocki stated that she felt bad about putting the purple band aid on Child A; however, Child A's Mother told her she did not believe he was allergic to purple dye because she had been giving him purple juice and Skittle candy.

In regards to the injury, Ms. Wysocki stated that there was a scrape on the top layer of Child A's first finger. Nobody saw how the block hit him.

I then spoke with Rebekah Armstrong. She stated that she was helping to clean up after the art project when Child A came up to her and asked her to wash paint off his hand. When she washed Child A's hand, she saw that there was some skin hanging off his finger, and she asked Ms. Wysocki for a band aid.

She asked Child A what happened and he stated that he was playing with another child and they hit blocks. Ms. Armstrong stated that as soon as the band aid went on, Child A got weak and he fell into her. Ms. Wysocki went to get Ms. Hirmaz to help with Child A. Another assistant caregiver was then sent into the room with her when Ms. Wysocki went with Child A.

On 05/01/2013, I completed an exit conference with Ms. Hirmaz. I commended her for taking appropriate action with regards to contacting 911 and Child A's Mother immediately. Ms. Hirmaz stated that she and the assistant caregiver's did not really know why Child A was reacting the way he was and were concerned about it being an allergic reaction to the purple dye. I also let her know that the center is in violation of the rules for notification to the department. Consultation and Technical Assistance was provided with regards to notifying the department of accidents or injuries that result in emergency medical treatment for a medical condition occurring while the child is in care at the center. Verbal notification was required within 24 hours and a written report was required within 72 hours.

APPLICABLE RULE	
R 400.5111a	**Accident, injury, illness, death reporting.**
	(1) The center shall make a verbal report to the department within 24 hours of a serious injury, or accident, or a serious illness or medical condition occurring while a child is in care that results in emergency medical treatment at a health facility or hospitalization, or death.
ANALYSIS:	The center did not make a verbal report to the department within 24 hours of Child A's injury that caused them to seek emergency medical treatment by contacting 911 and follow-up at a pediatrician's office that evening with Child A's Mother.
CONCLUSION:	VIOLATION ESTABLISHED

APPLICABLE RULE	
R 400.5111a	**Accident, injury, illness, death reporting.**
	(2) The center shall submit a written report in a format provided by the department within 72 hours of a serious injury or accident, or a serious or medical condition which results in emergency medical treatment at a health facility or hospitalization, or death. A copy of the report shall be kept on file at the center.

ANALYSIS:	The center did not submit a written report in a format provided by the department within 72 hours of Child A's injury that caused them to seek emergency medical treatment by contacting 911 and follow-up at the pediatrician's office that evening with Child A's Mother.
CONCLUSION:	VIOLATION ESTABLISHED

IV. RECOMMENDATION

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

Christine Noel

05/22/13

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Christine Noel Date
Licensing Consultant

Approved By:

Jacquelin Sharkey

05/22/2013

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Jacquelin Sharkey Date
Area Manager