DEPARTMENT OF CHILDREN AND FAMILIES
Division of Early Care and Education

STATE OF WISCONSIN

| Date Correction Plan Due | NONCOMPLIANCE STATEMENT AND CORRECTION PLAN | TO FILE A COMPLAINT CALL |
|---|---|---|
| 3/24/2022 | | 715-930-1148 |

**Use of Form:** This form is used by certification / licensing staff to identify statute and / or administrative rule violation(s) and to outline imposed plans of correction, if applicable. This form is used by certified operators / licensed centers to meet the requirements of DCF 202.065, DCF 250.04(2)(i) and (3)(d), DCF 251.04(2)(L) and (3)(f)., DCF 252.41(1)(L) and (2)(k). Failure to submit an appropriate correction plan by the due date listed above may result in sanctions identified in the statute and / or administrative rule. Public Schools may submit plans of correction however are not required to do so.

**Instructions:** The Noncompliance Statement below identifies the violation(s) of child care statute and / or administrative rule identified by the certification / licensing specialist. Complete the section labeled "Correction Plan" by indicating the steps that will be taken to address and correct each of the listed noncompliance(s). Identify expected completion date(s) for each item. Return the original to your certification / licensing specialist for approval and retain a copy. If this is a licensed child care, post your copy of the noncompliance statement and correction plan near the license in accordance with Wis. Stat. 48.657. This request for a correction plan is not an order imposing a sanction or penalty pursuant to Wis. Stat. 48.715. If the department decides to apply a statutory sanction and / or penalty for facts arising from this finding or a future finding, you will be given a notice of the sanction and / or penalty and your appeal rights.

| Name - Certified Operator / Licensed Center | | Provider Number / Facility ID Number |
|---|---|---|
| Barb's Little Blessings Childcare | | 1000587661 / 001 - 2000997 |
| **Address - Facility (Street, City, State, Zip Code)** | **Telephone Number** | **Date - Regulation Visit** |
| 205 Smith Cir River Falls WI 540224877 | 612-280-1592 | 3/8/2022 |

| | Rule/Statute Number<br>Noncompliance Statement | Correction Plan | Expected Completion Date | Verification Date |
|---|---|---|---|---|
| 1 | 250.04(6)(a)4.b.<br>**Child Record - Physical Exam - Over 2, Under 5**<br><br>Description: On 3/8/22, A current Health Examination Report was not observed on file for Child # 1 and 2. | I notify the Parents to I&I after each visit. Told them this form was overdue. Will continue to have parents update forms Finished going forward. The children went to doctor 1/12/22 (Updated) | Was completed Form on 3-15-2022 | |
| 2 | 250.04(6)(b)<br>**Current, Accurate Daily Attendance Record**<br><br>Description: On 3/8/22, a current written record of daily attendance of children in care was not observed on 3/7/22 and 3/8/22. | I completed it on 3-8-2022, and I am current each day, Going forward | Was completed on 3-8-2022 | |

**NAME** - Certification Worker / Licensing Specialist
Sarah Yang

Date Issued
3/10/2022

**SIGNATURE** - Certified Operator or Designee / Licensee or Designee
Barb J Hennen

Date Signed
3-15-2022

and DCF 251.07(6)(k)3. Failure to comply with these rules may result in issuance of a noncompliance statement. Personal information you provide may be used for secondary purposes [Privacy Law, s.15.04(1)(m), Wisconsin Statutes].

**Instructions:** Each child under 2 years of age shall have an initial health examination not more than 6 months prior to nor later than 3 months after being admitted to the center and a follow-up health examination at least once every 6 months after admission. Except for a school-aged child, each child 2 years of age or older shall have an initial health examination not more than one year prior to nor later than 3 months after being admitted to a center and a follow-up health examination at least once every 2 years after admission.

**PARENT OR GUARDIAN – Complete this section.**

| Name – Child (Last, First, MI) | Birthdate – Child (mm/dd/yyyy) |
|---|---|
| Koranda, Claire, F | |

Address – Child (Street, City, State, Zip Code)
224 Smith Circle, River Falls, WI 54022

Name – Parent or Guardian (Last, First, MI)
Koranda, Maureen, F

Address – Parent or Guardian (Street, City, State, Zip Code)
224 Smith Circle, River Falls WI 54022

**HEALTH PROFESSIONAL – Complete this section.**

Instructions for feeding and care of child with special problems, including allergies – Specify (attach information as necessary).

NA

☐ Yes ☒ No Does the child have a milk allergy? If "Yes", identify the recommended milk substitute.

Date of most recent blood lead test: 01/16/20 (mm/dd/yyyy). Note: Children on Medicaid are required to be tested at around ages 12 months and 24 months or once between the ages of 3 and 5 years if no previous test is documented. Lead testing is optional for children who are not on Medicaid.

Immunization(s) not to be administered to child due to medical reason(s) – Specify.

NA

**AUTHORIZATION**

I certify that I have examined the above child on this date and that he / she is able to participate in child care activities.

| Name – MD, PA or HealthCheck Provider (type or print) | Address (Street, City, State, Zip Code) |
|---|---|
| K Delong MD | 1617 Division St., River Falls WI 54022 |

SIGNATURE – MD, PA or HealthCheck Provider
K Delong MD

Date of Examination
01/18/22

DCF-F-CFS0060-E (R. 05/2010)

and DCF 251.07(6)(k)3. Failure to comply with these rules may result in issuance of a noncompliance statement. Personal information you provide may be used for secondary purposes [Privacy Law, s 15.04(1)(m), Wisconsin Statutes].

**Instructions:** Each child under 2 years of age shall have an initial health examination not more than 6 months prior to nor later than 3 months after being admitted to the center and a follow-up health examination at least once every 6 months after admission. Except for a school-aged child, each child 2 years of age or older shall have an initial health examination not more than one year prior to nor later than 3 months after being admitted to a center and a follow-up health examination at least once every 2 years after admission.

**PARENT OR GUARDIAN – Complete this section.**

| Name – Child (Last, First, MI) | Birthdate – Child (mm/dd/yyyy) |
|---|---|
| Koranda, Lauren, F | 01/05/2018 |

Address – Child (Street, City, State, Zip Code)
224 Smith Circle, River Falls, WI 54022

Name – Parent or Guardian (Last, First, MI)
Koranda, Maureen, F

Address – Parent or Guardian (Street, City, State, Zip Code)
224 Smith Circle, River Falls, WI 54022

**HEALTH PROFESSIONAL – Complete this section.**

*Instructions for feeding and care of child with special problems, including allergies – Specify (attach information as necessary).*

NA

☐ Yes ☒ No Does the child have a milk allergy? If "Yes", identify the recommended milk substitute.

*Date of most recent blood lead test:* 01/06/20 (mm/dd/yyyy). Note: Children on Medicaid are required to be tested at around ages 12 months and 24 months or once between the ages of 3 and 5 years if no previous test is documented. Lead testing is optional for children who are not on Medicaid.

Immunization(s) not to be administered to child due to medical reason(s) – Specify.

NA

**AUTHORIZATION**

I certify that I have examined the above child on this date and that he / she is able to participate in child care activities.

| Name – MD, PA or HealthCheck Provider (type or print) | Address (Street, City, State, Zip Code) |
|---|---|
| K. DeLong MD | 1617 Division St., River Falls WI 540 |

SIGNATURE – MD, PA or HealthCheck Provider: K. DeLong MD

Date of Examination: 01/18/20

DCF-F-CFS0060-E (R. 05/2010)