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
3/6/2025		262-446-7800

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	
Kindercare Learning Ctrs-Premier		0000555710 / 031 - 1000036	
Address - Facility (Street, City, State, Zip Code) W180 N9410 Premier Ln Menomonee Falls WI 53051	**Telephone Number** 262-532-0098	**Date - Regulation Visit** 2/19/2025	

	Rule/Statute Number Noncompliance Statement	Correction Plan	Expected Completion Date	Verification Date
1	251.05(2)(a)3.a. **Staff Record - Physical Examination** Description: There was no documentation of a staff health report for Staff B.	rescheduled nurse to come out for exam.	3/3/25	

NAME - Agency Worker
Rhonda Brueggemann, Katrina Tarantino

Date Issued
2/19/2025

SIGNATURE - Certified Operator or Designee / Licensee or Designee

Date Signed
3/3/25

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dcf.wisconsin.gov

STAFF HEALTH REPORT – LICENSED CHILD CARE CENTERS

Use of form: Use of this form is voluntary; however, completion of this form meets the requirements of DCF 250.05(2)(d) and DCF 251.05(2)(a)3.a. of the Wisconsin Administrative Code. 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: The examining health professional will complete this form, sign Section B, and return the completed form to the individual for placement in the staff file.

A. STAFF INFORMATION FCC: provider, employee, substitute. GCC: persons who work directly with children except volunteers.

Name (Last, First, MI)	Position Title
Schwenn, Sierra, J	KK Teacher

B. PHYSICAL EXAMINATION

☒ Yes ☐ No I certify based upon my examination that this person appears free of symptoms of illness, including tuberculosis, or communicable disease that may be transmitted through normal contact.

☒ Yes ☐ No I certify based upon my examination that this person appears to be physically able to work with children.

NOTE: This individual will be in contact with children receiving child care services and may be responsible for the physical care and social development of young children during the hours child care is provided. Some lifting of young children may be required.

Comments:

Allergies Environmental

Surgeries Cavities

Meds Albuterol

Health Hx – Asthma

5.4.52 Heart

Hgt 5'4

Wgt 95

P 66

B/P 90/40

Lungs Clear

Ros WNL

SIGNATURE – MD, PA or other Health Check Provider	Name – Examining Health Professional (Type or Print)
[signature] FNP	Sustin Nps
Address – Health Professional Office (Street, City, State, Zip)	Date Signed (mm/dd/yyyy)
1237 S. 16th St. Westfield WI	7/5/25

53014