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
9/2/2020		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	
Guadalupe Center South		3000563563 / 003 - 2004832	
Address - Facility (Street, City, State, Zip Code) 239 W Washington St Milwaukee WI 532042442	**Telephone Number** 414-999-4459	**Date - Regulation Visit** 8/17/2020	

	Rule/Statute Number Noncompliance Statement	Correction Plan	Expected Completion Date	Verification Date
1	251.05(2)(a)3.a. **Staff Record - Physical Examination** Description: Staff A did not have documentation in staff file of completed health report.	Staff has documentation in her file of completed health report, copy of completed health report was @ main office, now it is in her file @ this location.	8/19/2020	

NAME - Certification Worker / Licensing Specialist
Joel Marquez

Date Issued
8/19/2020

SIGNATURE - Certified Operator or Designee / Licensee or Designee

Date Signed
8/19/2020

Aurora Health Care • Milwaukee, Wisconsin

Aurora Occupational Health Services (AOHS)

Site: Aurora Occupational Health
~~4111 W Mitchell St. #300A~~
Milwaukee, WI 53215

EPI 4257723
LOERA,MARIA E
DoB 5/22/1975
90899-HACKER, KEITH J
SOURCE:

MEDICAL HISTORY AND PHYSICAL EXAMINATION

Company Name: United Community Center Job Title: K3 - Teachear

Date	Name		Date of Birth
6/5	Maria E. Loera		5/22/1975
Address: 3313 W. Hayes	City: Milwaukee	State: WS	Zip Code: 53215

I understand that this is an evaluation and that my participation does not imply a Doctor/Patient relationship with the examining medical provider. I hereby certify that I have carefully read and completed the following questions, that I understand them and that the information given is complete, true and accurate to the best of my knowledge. I understand that the falsification or misrepresentation of any of the information, or the failure or neglect to disclose any information requests, may be grounds for termination, regardless of when such falsification, misrepresentation, failure or neglect may be discovered.

Employee's Signature Maria L Date 6/5/20

(Continue to Page 2)

FOR MEDICAL PROVIDER USE ONLY

The information used to determine job requirements:

- ☑ Statement of employee/applicant
- ☐ Job title supplied by employer
- ☐ Detailed physical essential functions for job from employer
- ☐ General Job Description

Type of examination performed:

- ☑ Preplacement
- ☐ Periodic
- ☐ Other:

Test results reviewed:

- ☐ Audiogram
- ☐ Blood Tests
- ☐ Pre-Placement Function Test (PPFT)
- ☐ EKG
- ☑ TB Test
- ☐ Spirometry
- ☐ Chest X-ray
- ☑ Vision
- ☐ Other:

☐ Medical Hold – Final results are pending. Date: Initials:
Employer notified: Date:
No information was received; applicant is called within 7 calendar days. Date: Initials:
If no response from patient, employer is called 14 calendar days with final results. Date: Initials:

EXAMINATION RESULTS

- ☑ Employee may work without restrictions
- ☐ Employee may work with restrictions (see below)
- ☐ Not medically qualified (see below)

TB pending

Patient is free from clinically communicable disease ☑ Yes ☐ No

Drug screen results will come from another source

Comments/Restrictions/Accommodations: None

☐ FINAL RESULTS Date (if different from below): Medical Provider Signature

Medical Provider Signature: Keith Hacker PA-C Exam Date: 6-5-2020

Results ☐ Faxed ☐ Emailed ☐ Mailed to on by

Aurora Health Care — Milwaukee, Wisconsin

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Site: Aurora Occupational Health
4111 W Mitchell St. #300A
Milwaukee, WI 53215

EPI 4257723
LOERA,MARIA E
DoB 5/22/1975
90899-HACKER, KEITH J
SOURCE:

Tuberculosis (TB) SCREENING FORM

NAME (Print)	Date of Birth
Maria E. Loera	05/22/75

☐ Yes ☒ No Have you ever had a positive TB test? (Quantiferon Gold blood test or Purified Protein Derivative (PPD) skin test)
- If yes, when was the positive test? _____
- What type of treatment did you receive? _____

☐ Yes ☑ No Have you ever received the Bacillus Calmette-Guerin (BCG) vaccine to prevent TB?

☐ Yes ☑ No 1. Were you born in, have you traveled to, or have you lived in a country with high TB prevalence? *
- Includes any country other than the United States, Canada, Australia, New Zealand, or a country in western or northern Europe
- Travel is of extended duration (greater than 6 months) or including likely contact with infectious TB in a location of high TB prevalence

☐ Yes ☑ No 2. Have you had close contact to someone with infectious TB disease during your lifetime? *

☐ Yes ☒ No 3. Have you experienced recent TB symptoms: cough lasting 3 weeks AND one or more of the following: coughing up blood, fever, night sweats, unexplained weight loss, or fatigue?

☐ Yes ☑ No 4. Are you a current or former employee or resident at a facility (shelter, correctional center, long-term care center) in any of the following states or districts? *
- Includes Alaska, California, Florida, Hawaii, New Jersey, New York, Texas, or Washington DC
- Includes correctional facility, long-term residential care facility, or shelter for the homeless

☐ Yes ☑ No 5. Are you currently on or plan to take medications that affect your immune system, such as prednisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis; or have you had radiation treatments? *

☐ Yes ☑ No 6. Have you received a live vaccine within the last 4-6 weeks (not including vaccines you received today)?*

All people with a previous history of Tuberculosis, or positive TB test, may have latent TB infection and may be at risk of developing an active TB infection in the future. If you should develop any of the above symptoms (see #3 above), which are suggestive of active TB infection, you should report it to your employer.

Employee Signature: Maria E. Loera **Date:** 6/5 **Time:** _____

TB Skin Test #1	TB Skin Test #2
Sanofi 0.1 ml C5697AA 4/22 (Manufacturer / Dose / Lot # / Exp.)	_____ (Manufacturer / Dose / Lot # / Exp.)
PPD Skin Test Administered on 6-4-20 (Date) at 920 (Time)	PPD Skin Test Administered on _____ (Date) at _____ (Time)
In ☐ Right ☒ Left	In ☐ Right ☐ Left
Clajeak LPN (Administered By (Signature))	_____ (Administered By (Signature))
Interpretation: Induration only 0 mm ☐ No show for Read	Interpretation: Induration only _____ mm ☐ No show for Read
6/8/2020 (Date) 730 (Time) Mary Kennedy (Interpreted by (signature))	_____ (Date) _____ (Time) _____ (Interpreted by (signature))

Quantiferon Gold Date Tested: _____ Result: ☐ Positive ☐ Negative ☐ Indeterminate

CXR Performed: ☐ Yes (Date/Result: _____) ☐ No

Referred to: _____

Provider Signature *(when required)*: _____ Date _____

*** See back for detailed explanation**

* X 1 7 0 8 2 *

TB SCREENING FORM
(TB Screen)

White - Medical Record / Yellow - Patient
Pink - Department
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Aurora Health Care • Milwaukee, Wisconsin

Aurora Occupational Health Services (AOHS)

Site: _____

Tuberculosis (TB) SCREENING FORM

NAME (Print)	Date of Birth
Maria L. Lopez	05/22/75

☐ Yes ☑ No Have you ever had a positive TB test? (Quantiferon Gold blood test or Purified Protein Derivative (PPD) skin test)
- If yes, when was the positive test? _____
- What type of treatment did you receive? _____

☐ Yes ☑ No Have you ever received the Bacillus Calmette-Guerin (BCG) vaccine to prevent TB?

☐ Yes ☑ No 1. Were you born in, have you traveled to, or have you lived in a country with high TB prevalence? *
- Includes any country other than the United States, Canada, Australia, New Zealand, or a country in western or northern Europe
- Travel is of extended duration (greater than 6 months) or including likely contact with infectious TB in a location of high TB prevalence

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Employee Signature: _____ **Date:** 6/1 **Time:** _____

TB Skin Test #1	**TB Skin Test #2**
Sanofi Pasteur C5697 AA 4/18/22 Manufacturer / Dose / Lot # / Exp.	_____ Manufacturer / Dose / Lot # / Exp.
PPD Skin Test Administered on 6-1-20 (Date) at 920 (Time)	PPD Skin Test Administered on _____ (Date) at _____ (Time)
In ☐ Right ☒ Left	In ☐ Right ☐ Left
Alejandra LPN Administered By (Signature)	_____ Administered By (Signature)
Interpretation: Induration only 0 mm ☐ No show for Read	Interpretation: Induration only _____ mm ☐ No show for Read
6-5-2020 (Date) 730 (Time) Mary Kornafel (Interpreted by (signature))	_____ (Date) _____ (Time) _____ (Interpreted by (signature))

Quantiferon Gold Date Tested: _____ **Result:** ☐ Positive ☐ Negative ☐ Indeterminate

CXR Performed: ☐ Yes (Date/Result: _____) ☐ No

Referred to: _____

Provider Signature *(when required)*: _____ Date _____

*** See back for detailed explanation**

* X 1 7 0 8 2 *

TB SCREENING FORM
(TB Screen)

White - **Medical Record** / Yellow - **Patient**
Pink - **Department**
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