Validating the Georgia Family Child Care Home Regulations by Crosswalking to *Stepping Stones 3rd Edition*

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Introduction

This analysis is part of the overall Validation Study of the Georgia Licensing System. This is an in-depth comparison in which the key risk assessment standards of the 3rd Edition of *Stepping Stones to Caring for Our Children* were crosswalked to the Georgia Family Child Care Home Regulations in order to validate their relevance and content. This is a continuation of the first approach to validation (Zellman & Fiene, 2012) that was initiated in the first phase of this Validation Study (see Fiene, 2013 for the results of the first phase of the study).

This is a necessary analysis that all states should complete in order to validate their child care regulations. By having *Stepping Stones (AAP, APHA, NRC, 2013) and Caring for Our Children (AAP, APHA, NRC, 2011)*, we now have national health and safety performance standards as a benchmark for regulatory development.

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References:

AAP, APHA, NRC (2011). *Caring for our children: National health and safety performance standards; Guidelines for early care and education programs. 3rd Edition*. Elk Grove Village, IL: American Academy of Pediatrics; Washington, DC: American Public Health Association.

AAP, APHA, NRC (2013). *Stepping stones to caring for our children: National health and safety performance standards; Guidelines for early care and education programs. 3rd Edition*. Elk Grove Village, IL: American Academy of Pediatrics; Washington, DC: American Public Health Association.

Fiene (2013). *Georgia child care licensing study: Validating the core rule differential monitoring system*, Research Institute for Key Indicators, Middletown, Pennsylvania.

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LEGEND:

STEPPING STONES STANDARD = STEPPING STONES ARE THE SUBSET STANDARDS FROM *CARING FOR OUR CHILDREN*.

DECAL LICENSING RULE = GEORGIA CHILD CARE LICNESING RULE/REGULATION.

ANALYSIS = EXCEEDS, MEETS, PARTIALLY MEETS, DOES NOT MEET, NOT ADDRESSED.

ANALYSIS CLARIFICATION = PROVIDES DETAILS OF THE ANALYSIS, WHAT IT MEANS TO DECAL.

RECOMMENDATION = BASED UPON THE ANALYSIS CLARIFICATION, RECOMMENDATION(S) ARE MADE REGARDING CHANGES TO DECAL RULE FORMULATION.

NEXT STEPS = STEPS THAT DECAL WILL FORMULATE BASED UPON THE CROSSWALK AND ANALYSES.

FOOTNOTE: It should be noted that the Core Rules are all contained within the crosswalk to Stepping Stones which validates their selection as key risk assessment rules.

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Stepping Stones Standard	DECAL Licensing Rule	Analysis	Analysis Clarification	Recommendation	Next Steps
STANDARD 1.1.1.: Ratios Small Homes If the small family child care home caregiver/teacher has no children under two years of age in care, then the small family child care home caregiver/teacher may have one to six children over two years of age in care. If the small family child care home caregiver/teacher has one child under two years of age in care, then the small family child care home caregiver/teacher may have one to three children over two years of age in care. If the small family child care home caregiver/teacher has two children under two years of age in care, then the small family child care home caregiver/teacher may have no children over two years of age in care.	**290-2-3-.07 Staffing and Supervision** (6) Notwithstanding the limitation to six children prescribed by the definition of a family day care home, a provider may care for two additional children who are three years and older for two designated one hour periods daily upon approval by the department. (7) At least one adult shall supervise children at all times. Such adult, if not the provider, shall receive orientation regarding these rules; the provider's policies regarding discipline, injuries and illnesses, and release of children; the provider's written plan for handling emergencies; and appropriate information about any child's specific health needs. Plans shall be made to obtain additional adult help in cases of emergencies. (8) Effective one year from the effective date of this chapter, whenever other children are present in the home (the provider's own children, other related children, other children who also reside in the home, children for whom no pay or compensation is received, etc.) the total number of children present under the age of thirteen years may not exceed twelve, and the space requirement of 35 square feet per child (Rule .13(1)(a)) must be met. (a) Effective one year from the effective date of this chapter, an employee who must be at least 16 years of age must be present to assist with supervision whenever: 1. more than three children under the age of 12 months are present; or	Does not Meet.	None of the ratios meet the Stepping Stones standard.	Revise rules according to the ratios within Stepping Stones. If DECAL cannot revise all the ratios to start with then it is recommended to start with infants and toddlers followed by preschoolers and school age children. One always wants to start with our most vulnerable children who would be the youngest age children.	

	2. more than six children under the age of three years are present; or 3. more than eight children under the age of five years are present.				
STANDARD 1.1.1.4: Ratios and Supervision During Transportation Child:staff ratios established for out-of-home child care should be maintained on all transportation the facility provides or arranges. Drivers should not be included in the ratio. No child of any age should be left unattended in or around a vehicle, when children are in a car, or when they are in a car seat. A face-to-name count of children should be conducted prior to leaving for a destination, when the destination is reached, before departing for return to the facility and upon return. Caregivers/teachers should also remember to take into account in this head count if any children were picked up or dropped off while being transported away from the facility.		Not addressed.		DECAL may want to address this specific standard and add it to their rules.	
STANDARD 1.1.1.5: Ratios and Supervision for Swimming, Wading, and Water Play The following child:staff ratios should apply while children are swimming, wading, or engaged in water play: **Developmental Levels — Child:Staff Ratio** Infants — 1:1 Toddlers — 1:1 Preschoolers — 4:1 School-age Children — 6:1 Constant and active supervision should be maintained when any child is in or around water (4). During any swimming/wading/water play activities where either an infant or a toddler is present, the ratio should always be one adult to one infant/toddler. The required ratio of adults to older children should be met without including the adults who are required for supervision of infants and/or toddlers. An adult should remain in direct physical contact with an infant at all times during swimming or water play (4).	**290-2-3-.07 Staffing and Supervision** (a) For water-related activities where water is over two feet in depth, the following staff:child ratios shall be maintained: Ages of Children Staff: Child Ratio Under 2 1/2 1:2 2 1/2 to 4 years 1:5 4 years & older (who cannot swim a distance of 15 yds. unassisted) 1:6 4 years & older (who can swim a distance of 15 yds) 1:8.	Does not meet.	None of the adult-child ratios meet Stepping Stones Standard for ratios for swimming, wading and water play.	Revise rules according to the ratios within Stepping Stones starting with infants and toddlers.	

Whenever children thirteen months and up to five years of age are in or around water, the supervising adult should be within an arm's length providing "touch supervision" (6). The attention of an adult who is supervising children of any age should be focused on the child, and the adult should never be engaged in other distracting activities (4), such as talking on the telephone, socializing, or tending to chores. A lifeguard should not be counted in the child:staff ratio.					
STANDARD 1.2.0.2: Background Screening The background screening should include: a) Name and address verification; b) Social Security number verification; c) Education verification; d) Employment history; e) Alias search; f) Driving history through state Department of Motor Vehicles records; g) Background screening of: 1) State and national criminal history records; 2) Child abuse and neglect registries; 3) Licensing history with any other state agencies (i.e., foster care, mental health, nursing homes, etc.); 4) Fingerprints; and 5) Sex offender registries; h) Court records; i) References. All family members over age ten living in family child care homes should also have background screenings. Drug tests may also be incorporated into the background screening. Written permission to obtain the background screening (with or without a drug screen) should be obtained from the prospective employee. Consent to the background investigation should be required for employment consideration. When checking references and when conducting employee or volunteer interviews, prospective employers should specifically ask about previous convictions and arrests, investigation findings, or court cases with child abuse/neglect or child sexual abuse. Failure of the prospective employee to disclose previous history of child abuse/neglect or child sexual abuse is grounds for immediate dismissal.	**290-2-3-.04 Registration Requirements and Applications** (c) Criminal Records Check Required. The provider and employees of a home must submit to criminal records checks in connection with any application for a registration. 1. Preliminary Records Check. Before a registration to operate a home may be issued there shall be on file with the department a satisfactory preliminary criminal records check determination on the provider and a preliminary records check application for all employees, to include adult persons who reside at the home or who, with or without compensation, perform duties at the home which include personal contact between that adult person and children in care. 2. Ongoing Requirements. Before a person may work in a registered home, the provider shall cause the person to be employed to submit a preliminary records check application to the department. The provider shall also cause any adult person, as defined in subparagraph 1. above, to submit a preliminary records check application to the department. (i) No person having an unsatisfactory determination as to his or her criminal record may be a provider or employee of a home. No adult person having an unsatisfactory determination as to his or her criminal record may reside at the home	Partially meets.	The DECAL Rule calls for a criminal records check for caregivers but does not provide any of the detail as delineated in the Stepping Stone Standard.	Revise the Rule so that a comprehensive background screening with all the items in the Stepping Stones standard are included.	

Persons should not be hired or allowed to work or volunteer in the child care facility if they acknowledge being sexually attracted to children or having physically or sexually abused children, or are known to have committed such acts. Background screenings should be repeated periodically taking into consideration state laws and/or requirements. Screenings should be repeated more frequently if there are additional concerns.	and have contact with children.				
STANDARD 1.3.3.1: General Qualifications of Family Child Care Caregivers/Teachers to Operate a Family Child Care Home All caregivers/teachers in small family child care homes should be at least twenty-one years of age, hold an official credential as granted by the authorized state agency, and should have the following education, experience, and skills: a) Current accreditation by the National Association for Family Child Care (NAFCC) (including entry-level qualifications and participation in required training) and a college certificate representing a minimum of three credit hours of early childhood education leadership or master caregiver/teacher training or hold an Associate's degree in early childhood education or child development; b) A provider who has been in the field less than twelve months should be in the self-study phase of NAFCC accreditation; c) A valid certificate in pediatric first aid, including CPR; d) Pre-service training in health management in child care, including the ability to recognize signs of illness, knowledge of infectious disease prevention and safety injury hazards; e) If caring for infants, knowledge on safe sleep practices including reducing the risk of sudden infant death syndrome (SIDS) and prevention of shaken baby syndrome/abusive head trauma (including how to cope with a crying infant); f) Knowledge of normal child development, as well as knowledge of indicators that a child is not developing typically; g) The ability to respond appropriately to children's needs; h) Good oral and written communication skills; i) Willingness to receive ongoing mentoring from other teachers; j) Pre-service training in business practices; k) Knowledge of the importance of nurturing adult-child relationships on self-efficacy development; l) Medication administration training	**290-2-3-.07 Staffing and Supervision.** (1) The provider shall be at least 21 years of age. (2) Effective July 1, 2009, providers who apply for initial registration shall submit valid evidence/documentation of one of the following credentials/degrees issued by either the organizations listed below, an accredited educational institution, or another organization approved/recognized by the department: (a) Child Development Associate (CDA) credential (issued by the Council for Professional Recognition); (b) Technical Certificate of Credit (TCC) in Early Childhood Education; (c) Technical College Diploma (TCD) in Early Childhood Education; (d) Associate Degree in Early Childhood Education (AA, AAS, AAT); (e) Paraprofessional Certificate (issued by the Georgia Professional Standards Commission); (f) Bachelor's degree in Early Childhood Education; or (g) Master's degree in Early Childhood Education. (3) Family day care home providers and applicants who have submitted an application for registration or re-registration on or before June 30, 2009 shall be exempt from the requirement stated in (2)(a) through (g)	Meets.			

	above, except if the family day care home closes for business and then submits a new application for registration on or after July 1, 2009. Any family day care home provider who submits an application for registration on or after July 1, 2009 must meet one of the education requirements listed above. Any family day care home provider who submits a new application for registration on or before June 30, 2009 shall have a high school diploma, General Education Diploma (GED), or similar credentials and shall submit valid evidence/documentation of such credential. (4) The provider shall have current evidence of successful completion of a biennial training program in cardiopulmonary resuscitation (CPR) and a triennial training program in first aid which have been offered by certified or licensed health care professionals and which dealt with emergency care for infants and children. Additionally, within one year of the effective date of these rules and thereafter on an annual basis, the provider shall attend ten clock hours of diverse training which is related to care of children and which is offered by an accredited college, university or vocational program or other department approved source. Records of completion of such training programs shall be maintained in the home by the provider, as required by Rule .08(5). The ten clock hours of training shall be chosen from the following fields: (a) Child Development: including discipline, guidance, nutrition, injury control and safety; (b) Health: including sanitation, disease				

	control, cleanliness, detection and disposition of illness; (c) Child Abuse and Neglect: including identification and reporting, and meeting the needs of abused and/or neglected children; and (d) Business Related Topics: including parental communication, recordkeeping, etc.; provided however that such business related training shall be limited to no more than two of the required ten clock hours of training. **290-2-3-.04 Registration Requirements and Applications** 1. Qualifications Requirement. In order to obtain or retain a registration, the provider of the home and its employees must be qualified, as defined in these rules, to administer or work in a home. The department may presume that the provider and employees are qualified, subject to satisfactory determinations on the criminal records checks. However, the department may require additional reasonable verification of the qualifications of the provider and employees either at the time of application for a registration or at any other time whenever the department has reason to believe or is shown by credible evidence that a provider or employee is not qualified under these rules to administer or work in a home				
STANDARD 1.4.1.1: Pre-service Training In addition to the credentials listed in Standard 1.3.1.1, upon employment, a director or administrator of a center or the lead caregiver/teacher in a family child care home should provide documentation of at least thirty clock-hours of pre-service training. This training should cover health, psychosocial, and safety issues for out-of-home child care facilities. Small family child care home caregivers/teachers	**290-2-3-.04 Registration Requirements and Applications.** (a) Pre-Service Training. Prior to the submission of the registration application, the applicant who will be responsible for the day-to-day operations shall complete the preservice training listed below that has been approved by the department and which will include:	Partially meets.	This DECAL rule has the basic training areas but not the detail as specified in the Stepping Stones standard.	DECAL should see about adding the detail from the Stepping Stones standard.	

may have up to ninety days to secure training after opening except for training on basic health and safety procedures and regulatory requirements. All directors or program administrators and caregivers/ teachers should document receipt of pre-service training prior to working with children that includes the following content on basic program operations: a) Typical and atypical child development and appropriate best practice for a range of developmental and mental health needs including knowledge about the developmental stages for the ages of children enrolled in the facility; b) Positive ways to support language, cognitive, social, and emotional development including appropriate guidance and discipline; c) Developing and maintaining relationships with families of children enrolled, including the resources to obtain supportive services for children's unique developmental needs; d) Procedures for preventing the spread of infectious disease, including hand hygiene, cough and sneeze etiquette, cleaning and disinfection of toys and equipment, diaper changing, food handling, health department notification of reportable diseases, and health issues related to having animals in the facility; e) Teaching child care staff and children about infection control and injury prevention through role modeling; f) Safe sleep practices including reducing the risk of Sudden Infant Death Syndrome (SIDS) (infant sleep position and crib safety); g) Shaken baby syndrome/abusive head trauma prevention and identification, including how to cope with a crying/fussy infant; h) Poison prevention and poison safety; i) Immunization requirements for children and staff; j) Common childhood illnesses and their management, including child care exclusion policies and recognizing signs and symptoms of serious illness; k) Reduction of injury and illness through environmental design and maintenance; l) Knowledge of U.S. Consumer Product Safety Commission (CPSC) product recall reports; m) Staff occupational health and safety practices,	1. Orientation that provides, at a minimum, instruction on the application process and gives an overview of the department's rules and regulations that relate to the operation of the family day care home; 2. Training course that includes the provider competencies that serve as a framework for professional development, which includes, but is not limited to, early learning standards, communication, developmentally appropriate practices, professional and leadership development, business management, and advocacy for the family day care home, parents, children, and staff; 3. Cardiopulmonary resuscitation (CPR) and first aid training programs offered by certified or licensed health care professionals and approved by the department, which include emergency care for infants and children.				

such as proper procedures, in accordance with Occupational Safety and Health Administration (OSHA) bloodborne pathogens regulations; n) Emergency procedures and preparedness for disasters, emergencies, other threatening situations (including weather-related, natural disasters), and injury to infants and children in care; o) Promotion of health and safety in the child care setting, including staff health and pregnant workers; p) First aid including CPR for infants and children; q) Recognition and reporting of child abuse and neglect in compliance with state laws and knowledge of protective factors to prevent child maltreatment r) Nutrition and age-appropriate child-feeding including food preparation, choking prevention, menu planning, and breastfeeding supportive practices; s) Physical activity, including age-appropriate activities and limiting sedentary behaviors; t) Prevention of childhood obesity and related chronic diseases; u) Knowledge of environmental health issues for both children and staff; v) Knowledge of medication administration policies and practices; w) Caring for children with special health care needs, mental health needs, and developmental disabilities in compliance with the Americans with Disabilities Act (ADA); x) Strategies for implementing care plans for children with special health care needs and inclusion of all children in activities; y) Positive approaches to support diversity; z) Positive ways to promote physical and intellectual development.					
STANDARD 1.4.2.2: Orientation for Care of Children with Special Health Care Needs When a child care facility enrolls a child with special health care needs, the facility should ensure that all staff members have been oriented in understanding that child's special health care needs and have the skills to work with		Not addressed.			

that child in a group setting. Caregivers/teachers in small family child care homes, who care for a child with special health care needs, should meet with the parents/guardians and meet or speak with the child's primary care provider (if the parent/guardian has provided prior, informed, written consent) or a child care health consultant to ensure that the child's special health care needs will be met in child care and to learn how these needs may affect his/her developmental progression or play with other children. The orientation provided to staff in child care facilities should be based on the special health care needs of children who will be assigned to their care. All staff oriented for care of children with special health needs should be knowledgeable about the care plans created by the child's primary care provider in their medical home as well as any care plans created by other health professionals and therapists involved in the child's care. Child care health consultants can be an excellent resource for providing health and safety orientation or referrals to resources for such training. This training may include, but is not limited to, the following topics: a) Positioning for feeding and handling, and risks for injury for children with physical/mental disabilities; b) Toileting techniques; c) Knowledge of special treatments or therapies (e.g., PT, OT, speech, nutrition/diet therapies, emotional support and behavioral therapies, medication administration, etc.) the child may need/receive in the child care setting; d) Proper use and care of the individual child's adaptive equipment, including how to recognize defective equipment and to notify parents/guardians that repairs are needed; e) How different disabilities affect the child's ability to participate in group activities; f) Methods of helping the child with special health care needs or behavior problems to participate in the facility's programs, including physical activity programs; g) Role modeling, peer socialization, and interaction; h) Behavior modification techniques, positive behavioral supports for children, promotion of self-esteem, and other techniques for managing					

behavior; i) Grouping of children by skill levels, taking into account the child's age and developmental level; j) Health services or medical intervention for children with special health care problems; k) Communication methods and needs of the child; l) Dietary specifications for children who need to avoid specific foods or for children who have their diet modified to maintain their health, including support for continuation of breastfeeding; m) Medication administration (for emergencies or on an ongoing basis); n) Recognizing signs and symptoms of impending illness or change in health status; o) Recognizing signs and symptoms of injury; p) Understanding temperament and how individual behavioral differences affect a child's adaptive skills, motivation, and energy; q) Potential hazards of which staff should be aware; r) Collaborating with families and outside service providers to create a health, developmental, and behavioral care plan for children with special needs; s) Awareness of when to ask for medical advice and recommendations for non-emergent issues that arise in school (e.g., head lice, worms, diarrhea); t) Knowledge of professionals with skills in various conditions, e.g., total communication for children with deafness, beginning orientation and mobility training for children with blindness (including arranging the physical environment effectively for such children), language promotion for children with hearing-impairment and language delay/disorder, etc.; u) How to work with parents/guardians and other professionals when assistive devices or medications are not consistently brought to the child care program or school; v) How to safely transport a child with special health care needs.					
STANDARD 1.4.2.3: Orientation Topics During the first three months of employment, the caregiver/teacher in a small family home should document satisfactory knowledge of the following topics:	**290-2-3-.04 Registration Requirements and Applications.** 1. Orientation that provides, at a minimum, instruction on the application process and gives an overview of the department's	Partially meets.	The staff training rule meets certain aspects of the Stepping Stones standard but does not contain all the specific content areas.	DECAL could see about adding the additional items listed in the Stepping Stones standard to this rule.	

a) Recognition of symptoms of illness and correct documentation procedures for recording symptoms of illness. This should include the ability to perform a daily health check of children to determine whether any children are ill or injured and, if so, whether a child who is ill should be excluded from the facility; b) Exclusion and readmission procedures and policies; c) Cleaning, sanitation, and disinfection procedures and policies; d) Procedures for administering medication to children and for documenting medication administered to children; e) Procedures for notifying parents/guardians of an infectious disease occurring in children or staff within the facility; f) Procedures and policies for notifying public health officials about an outbreak of disease or the occurrence of a reportable disease; g) Emergency procedures and policies related to unintentional injury, medical emergency, and natural disasters; h) Procedure for accessing the child care health consultant for assistance; i) Injury prevention strategies and hazard identification procedures specific to the facility, equipment, etc.; j) Proper hand hygiene. Before being assigned to tasks that involve identifying and responding to illness, staff members should receive orientation training on these topics. Small family child care home caregivers/teachers should not commence operation before receiving orientation on these topics in pre-service training	rules and regulations that relate to the operation of the family day care home; 2. Training course that includes the provider competencies that serve as a framework for professional development, which includes, but is not limited to, early learning standards, communication, developmentally appropriate practices, professional and leadership development, business management, and advocacy for the family day care home, parents, children, and staff; **290-2-3-.07 Staffing and Supervision** (7) At least one adult shall supervise children at all times. Such adult, if not the provider, shall receive orientation regarding these rules; the provider's policies regarding discipline, injuries and illnesses, and release of children; the provider's written plan for handling emergencies; and appropriate information about any child's specific health needs. Plans shall be made to obtain additional adult help in cases of emergencies				
STANDARD 1.4.3.1: First Aid and CPR Training for Staff The caregiver/teacher of a small family child care home should have documentation of satisfactory completion of training in pediatric first aid and pediatric CPR skills. Pediatric CPR skills should be taught by demonstration, practice, and return demonstration to ensure the technique can be performed in an emergency. These skills should be current according to the requirement specified for retraining by the organization that provided the training.	**290-2-3-.07 Staffing and Supervision** (4) The provider shall have current evidence of successful completion of a biennial training program in cardiopulmonary resuscitation (CPR) and a triennial training program in first aid which have been offered by certified or licensed health care professionals and which dealt with emergency care for infants and children.	Meets			

Records of successful completion of training in pediatric first aid should be maintained in the personnel files of the facility.					
STANDARD 1.4.3.2: Topics Covered in First Aid Training First aid training should present an overview of Emergency Medical Services (EMS), accessing EMS, poison center services, accessing the poison center, safety at the scene, and isolation of body substances. First aid instruction should include, but not be limited to, recognition and first response of pediatric emergency management in a child care setting of the following situations: a) Management of a blocked airway and rescue breathing for infants and children with return demonstration by the learner (pediatric CPR); b) Abrasions and lacerations; c) Bleeding, including nosebleeds; d) Burns; e) Fainting; f) Poisoning, including swallowed, skin or eye contact, and inhaled; g) Puncture wounds, including splinters; h) Injuries, including insect, animal, and human bites; i) Poison control; j) Shock; k) Seizure care; l) Musculoskeletal injury (such as sprains, fractures); m) Dental and mouth injuries/trauma; n) Head injuries, including shaken baby syndrome/ abusive head trauma; o) Allergic reactions, including information about when epinephrine might be required; p) Asthmatic reactions, including information about when rescue inhalers must be used; q) Eye injuries; r) Loss of consciousness; s) Electric shock; t) Drowning; u) Heat-related injuries, including heat exhaustion/heat stroke; v) Cold related injuries, including frostbite;		Not addressed.		DECAL may want to address this specific standard and add it to their rules.	

w) Moving and positioning injured/ill persons; x) Illness-related emergencies (such as stiff neck, inexplicable confusion, sudden onset of blood-red or purple rash, severe pain, temperature above 101°F [38.3°C] orally, above 102°F [38.9°C] rectally, or 100°F [37.8°C] or higher taken axillary [armpit] or measured by an equivalent method, and looking/acting severely ill); y) Standard Precautions; z) Organizing and implementing a plan to meet an emergency for any child with a special health care need; aa) Addressing the needs of the other children in the group while managing emergencies in a child care setting; ab) Applying first aid to children with special health care needs.					
STANDARD 1.4.3.3: CPR Training for Swimming and Water Play For small family child care homes, the person trained in water safety and CPR should be the caregiver/teacher. Written verification of successful completion of CPR and lifesaving training, water safety instructions, and emergency procedures should be kept on file.	**290-2-3-.07 Staffing and Supervision** 9) If children are allowed to participate in water activities where the water is over two feet in depth, the provider or an adult shall supervise such activities and must have successfully completed a training program in lifeguarding offered by a water-safety instructor certified by the American Red Cross or YMCA or other recognized standard setting agency for water safety instruction.	Partially meets.	This rule states that the caregiver/teacher have completed a training program in lifeguarding but does not have any wording about CPR.	DECAL may want to add the specific language regarding CPR training.	
STANDARD 1.4.5.1: Training of Staff Who Handle Food All staff members with food handling responsibilities should obtain training in food service and safety. The director of a center or a large family child care home or the designated supervisor for food service should be a certified food protection manager or equivalent as demonstrated by completing an accredited food protection manager course.		Not addressed.		DECAL may want to address this specific standard and add it to their rules.	
STANDARD 1.4.5.2: Child Abuse and Neglect Education Caregivers/teachers should use child abuse and neglect	**290-2-3-.07 Staffing and Supervision** The ten clock hours of training shall be chosen from the following fields: (c) Child Abuse and Neglect: including	Partially meets.	The rule addresses training in identifying, reporting and meeting the needs of abused, neglected or deprived children; but does not go into	DECAL may want to add the additional language from the Stepping Stones standard.	

prevention education to educate and establish child abuse and neglect prevention and recognition measures for the children, caregivers/teachers, and parents/guardians. The education should address physical, sexual, and psychological or emotional abuse and neglect. The dangers of shaking infants and toddlers and repeated exposure to domestic violence should be included in the education and prevention materials. Caregivers/teachers should also receive education on promoting protective factors to prevent child maltreatment. Caregivers/teachers should be able to identify signs of stress in families and assist families by providing support and linkages to resources when needed. Children with disabilities are at a higher risk of being abused. Special training in child abuse and neglect and children with disabilities should be provided (2). Caregivers/teachers are mandatory reporters of child abuse or neglect. Caregivers/teachers should be trained in compliance with their state's child abuse reporting laws. Child abuse reporting requirements are known and available from the child care regulation department in each state.	identification and reporting, and meeting the needs of abused and/or neglected children;		any details regarding this training as stated in the Stepping Stones standard.		
STANDARD 1.5.0.2: Orientation of Substitutes The director of any center or large family child care home and the small family child care home caregiver/teacher should provide orientation training to newly hired substitutes to include a review of ALL the program's policies and procedures (listed below is a sample). This training should include the opportunity for an evaluation and a repeat demonstration of the training lesson. In all child care settings the orientation should be documented. Substitutes should have background screenings. All substitutes should be oriented to, and demonstrate competence in, the tasks for which they will be responsible. On the first day a substitute caregiver/teacher should be oriented on the following topics: a) Safe infant sleep practices if an infant is enrolled in the program; b) Any emergency medical procedure/medication needs of the children; c) Any nutrition needs of the children. All substitute caregivers/teachers, during the first week of employment, should be oriented to, and should demonstrate competence in at least the following items:	**290-2-3-.07 Staffing and Supervision** (7) At least one adult shall supervise children at all times. Such adult, if not the provider, shall receive orientation regarding these rules; the provider's policies regarding discipline, injuries and illnesses, and release of children; the provider's written plan for handling emergencies; and appropriate information about any child's specific health needs. Plans shall be made to obtain additional adult help in cases of emergencies.	Partially meets.	The rule addresses the need for substitutes to receive orientation training but provides not details of what this orientation should be.	DECAL may want to add the specifics from this standard.	

a) The names of the children for whom the caregiver/ teacher will be responsible, and their specific developmental needs; b) The planned program of activities at the facility; c) Routines and transitions; d) Acceptable methods of discipline; e) Meal patterns and safe food handling policies of the facility (special attention should be given to life-threatening food allergies); f) Emergency health and safety procedures; g) General health policies and procedures as appropriate for the ages of the children cared for, including but not limited to the following: 1) Hand hygiene techniques, including indications for hand hygiene; 2) Diapering technique, if care is provided to children in diapers, including appropriate diaper disposal and diaper changing techniques, use and wearing of gloves; 3) The practice of putting infants down to sleep positioned on their backs and on a firm surface along with all safe infant sleep practices to reduce the risk of Sudden Infant Death Syndrome (SIDS), as well as general nap time routines for all ages; 4) Correct food preparation and storage techniques, if employee prepares food; 5) Proper handling and storage of human milk when applicable and formula preparation if formula is handled; 6) Bottle preparation including guidelines for human milk and formula if care is provided to children with bottles; 7) Proper use of gloves in compliance with Occupational Safety and Health Administration (OSHA) bloodborne pathogens regulations; 8) Injury prevention and safety including the role of mandatory child abuse reporter to report any suspected abuse/neglect. h) Emergency plans and practices; i) Access to list of authorized individuals for releasing children.					
STANDARD 2.1.1.4: Monitoring Children's Development/Obtaining Consent for Screening		Not addressed.		DECAL may want to address this specific standard and add it to their rules.	

Child care settings provide daily indoor and outdoor opportunities for promoting and monitoring children's development. Caregivers/teachers should monitor the children's development, share observations with parents/guardians, and provide resource information as needed for screenings, evaluations, and early intervention and treatment. Caregivers/teachers should work in collaboration to monitor a child's development with parents/guardians and in conjunction with the child's primary care provider and health, education, mental health, and early intervention consultants. Caregivers/teachers should utilize the services of health and safety, education, mental health, and early intervention consultants to strengthen their observation skills, collaborate with families, and be knowledgeable of community resources. Programs should have a formalized system of developmental screening with all children that can be used near the beginning of a child's placement in the program, at least yearly thereafter, and as developmental concerns become apparent to staff and/or parents/guardians. The use of authentic assessment and curricular-based assessments should be an ongoing part of the services provided to all children (5-9). The facility's formalized system should include a process for determining when a health or developmental screening or evaluation for a child is necessary. This process should include parental/guardian consent and participation. Parents/guardians should be explicitly invited to: a) Discuss reasons for a health or developmental assessment; b) Participate in discussions of the results of their child's evaluations and the relationship of their child's needs to the caregivers'/teachers' ability to serve that child appropriately; c) Give alternative perspectives; d) Share their expectations and goals for their child and have these expectations and goals integrated with any plan for their child; e) Explore community resources and supports that might assist in meeting any identified needs that child care centers and family child care homes can provide; f) Give written permission to share health information with primary health care professionals (medical home), child care health consultants and					

other professionals as appropriate; The facility should document parents'/guardians' presence at these meetings and invitations to attend. If the parents/guardians do not attend the screening, the caregiver/teacher should inform the parents/guardians of the results, and offer an opportunity for discussion. Efforts should be made to provide notification of meetings in the primary language of the parents/guardians. Formal evaluations of a child's health or development should also be shared with the child's medical home with parent/guardian consent. Programs are encouraged to utilize validated screening tools to monitor children's development, as well as various measures that may inform their work facilitating children's development and providing an enriching indoor and outdoor environment, such as authentic-based assessment, work sampling methods, observational assessments, and assessments intended to support curricular implementation (5,9). Programs should have clear policies for using reliable and valid methods of developmental screening with all children and for making referrals for diagnostic assessment and possible intervention for children who screen positive. All programs should use methods of ongoing developmental assessment that inform the curricular approaches used by the staff. Care must be taken in communicating the results. Screening is a way to identify a child *at risk* of a developmental delay or disorder. It is not a diagnosis. If the screening or any observation of the child results in any concern about the child's development, after consultation with the parents/guardians, the child should be referred to his or her primary care provider (medical home), or to an appropriate specialist or clinic for further evaluation. In some situations, a direct referral to the Early Intervention System in the respective state may also be required.					
STANDARD 2.1.2.2: Interactions with Infants and Toddlers Caregivers/teachers should provide consistent, continuous and inviting opportunities to talk, listen to, and otherwise interact with young infants throughout the day (indoors and outdoors) including feeding, changing, playing with, and cuddling them.		Not addressed.		DECAL may want to address this specific standard and add it to their rules.	

STANDARD 2.2.0.1: Methods of Supervision of Children Caregivers/teachers should directly supervise infants, toddlers, and preschoolers by sight and hearing at all times, even when the children are going to sleep, napping or sleeping, are beginning to wake up, or are indoors or outdoors. School-age children should be within sight or hearing at all times. Caregivers/teachers should not be on one floor level of the building, while children are on another floor or room. Ratios should remain the same whether inside or outside. School-age children should be permitted to participate in activities off the premises with appropriate adult supervision and with written approval by a parent/guardian and by the caregiver. If parents/guardians give written permission for the school-age child to participate in off-premises activities, the facility would no longer be responsible for the child during the off-premises activity and not need to provide staff for the off-premises activity. Caregivers/teachers should regularly count children (name to face on a scheduled basis, at every transition, and whenever leaving one area and arriving at another), going indoors or outdoors, to confirm the safe whereabouts of every child at all times. Additionally, they must be able to state how many children are in their care at all times. Developmentally appropriate child:staff ratios should be met during all hours of operation, including indoor and outdoor play and field trips, and safety precautions for specific areas and equipment should be followed. No center-based facility or large family child care home should operate with fewer than two staff members if more than six children are in care, even if the group otherwise meets the child:staff ratio. Although centers often downsize the number of staff for the early arrival and late departure times, another adult must be present to help in the event of an emergency. The supervision policies of centers and large family child care homes should be written policies.	**290-2-3-.07 Staffing and Supervision** (7) At least one adult shall supervise children at all times.	Partially meets.	This rule addresses supervision but lacks specificity, such as: regularly counting children at transitions.	DECAL may want to add the additional language from the Stepping Stones standard to be more specific regarding supervision of children.	
STANDARD 2.2.0.10: Using Physical Restraint When a child with special behavioral or mental health is-	**290-2-3-.11 Health, Safety, and Discipline** (a) A provider or a home's employees shall not:	Partially meets.	This rule addresses the use of physical restraints but does not address a behavioral plan.	DECAL may want to add the development and use of a behavioral plan.	

sues is enrolled who may frequently need the cautious use of restraint in the event of behavior that endangers his or her safety or the safety of others, a behavioral care plan should be developed with input from the child's primary care provider, mental health provider, parents/guardians, center director/family child care home caregiver/teacher, child care health consultant, and possibly early childhood mental health consultant in order to address underlying issues and reduce the need for physical restraint. That behavioral care plan should include: a) An indication and documentation of the use of other behavioral strategies before the use of restraint and a precise definition of when the child could be restrained; b) That the restraint be limited to holding the child as gently as possible to accomplish the restraint; c) That such child restraint techniques do not violate the state's mental health code; d) That the amount of time the child is physically restrained should be the minimum necessary to control the situation and be age-appropriate; reevaluation and change of strategy should be used every few minutes; e) That no bonds, ties, blankets, straps, car seats, heavy weights (such as adult body sitting on child), or abusive words should be used; f) That a designated and trained staff person, who should be on the premises whenever this specific child is present, would be the only person to carry out the restraint.	6. Use mechanical or physical restraints or devices to discipline children;				
STANDARD 2.2.0.4: Supervision Near Bodies of Water Constant and active supervision should be maintained when any child is in or around water (1). During any swimming/ wading/water play activities where either an infant or a toddler is present, the ratio should always be one adult to one infant/toddler. Children ages thirteen months to five years of age should not be permitted to play in areas where there is any body of water, including swimming pools, ponds and irrigation ditches, built-in wading pools, tubs, pails, sinks, or toilets unless the supervising adult is within an arm's length providing "touch supervision". Caregivers/teachers should ensure that all pools meet the Virginia Graeme Baker Pool and Spa Safety Act, requiring the retrofitting of safe suction-type devices for pools and	**290-2-3-.07 Staffing and Supervision** (9) If children are allowed to participate in water activities where the water is over two feet in depth, the provider or an adult shall supervise such activities and must have successfully completed a training program in lifeguarding offered by a water-safety instructor certified by the American Red Cross or YMCA or other recognized standard setting agency for water safety instruction.	Partially meets.	The rule addresses supervision in water related activities but does not address the ratios suggested in the Stepping Stones standard for infants or toddlers, nor is there specific language regarding the Virginia Graeme Baker Pool and Spa Safety Act.	DECAL may want to add language about ratios for infants and toddlers and add specific language regarding the Virginia Graeme Baker Act.	

spas to prevent underwater entrapment of children in such locations with strong suction devices that have led to deaths of children of varying ages.					
STANDARD 2.2.0.6: Discipline Measures Caregivers/teachers should guide children to develop self-control and appropriate behaviors in the context of relationships with peers and adults. Caregivers/teachers should care for children without ever resorting to physical punishment or abusive language. When a child needs assistance to resolve a conflict, manage a transition, engage in a challenging situation, or express feelings, needs, and wants, the adult should help the child learn strategies for dealing with the situation. Discipline should be an ongoing process to help children learn to manage their own behavior in a socially acceptable manner, and should not just occur in response to a problem behavior. Rather, the adult's guidance helps children respond to difficult situations using socially appropriate strategies. To develop self-control, children should receive adult support that is individual to the child and adapts as the child develops internal controls. This process should include: a) Forming a positive relationship with the child. When children have a positive relationship with the adult, they are more likely to follow that person's directions. This positive relationship occurs when the adult spends time talking to the child, listening to the child, following the child's lead, playing with the child, and responding to the child's needs; b) Basing expectations on children's developmental level; c) Establishing simple rules children can understand (e.g., you can't hurt others, our things, or yourself) and being proactive in teaching and supporting children in learning the rules; d) Adapting the physical indoor and outdoor learning/ play environment or family child care home to encourage positive behavior and self regulation by providing engaging materials based on children's interests and ensuring that the learning environment promotes active participation of each child. Well-designed child care environments are ones that are supportive of appropriate behavior in children, and are designed to help children learn about what to expect in that	**290-2-3-.11 Health, Safety, and Discipline** (3) Discipline. Disciplinary actions used to correct a child's behavior, guidance techniques and any activities in which the children participate or observe at the home shall not be detrimental to the physical or mental health of any child.	Partially Meets	The rule as written is very general with none of the specificity contained in the Stepping Stones standard.	DECAL should look at the exact wording from Stepping Stones to determine where this rule can be strengthened by adding the greater specificity.	

environment and to promote positive interactions and engagement with others; e) Modifying the learning/play environment (e.g., schedule, routine, activities, transitions) to support the child's appropriate behavior; f) Creating a predictable daily routine and schedule. When a routine is predictable, children are more likely to know what to do and what is expected of them. This may decrease anxiety in the child. When there is less anxiety, there may be less acting out. Reminders need to be given to the children so they can anticipate and prepare themselves for transitions within the schedule. Reminders should be individualized such that each child understands and anticipates the transition; g) Using encouragement and descriptive praise. When clear encouragement and descriptive praise are used to give attention to appropriate behaviors, those behaviors are likely to be repeated. Encouragement and praise should be stated positively and descriptively. Encouragement and praise should provide information that the behavior the child engaged in was appropriate. Examples: "I can tell you are ready for circle time because you are sitting on your name and looking at me." "Your friend looked so happy when you helped him clean up his toys." "You must be so proud of yourself for putting on your coat all by yourself." Encouragement and praise should label the behaviors, not the child (e.g., good listening, good eating, instead of good boy); h) Using clear, direct, and simple commands. When clear commands are used with children, they are more likely to follow them. The caregiver/teacher should tell the child what to do rather than what NOT to do. The caregiver/teacher should limit the number of commands. The caregiver/teacher should use if/ then and when/then statements with logical and natural consequences. These practices help children understand they can make choices and that choices have consequences; i) Showing children positive alternatives rather than just telling children "no"; j) Modeling desired behavior; k) Using planned ignoring and redirection. Certain behaviors can be ignored while at the same time					

the adult is able to redirect the children to another activity. If the behavior cannot be ignored, the adult should prompt the child to use a more appropriate behavior and provide positive feedback when the child engages in the behavior; l) Individualizing discipline based on the individual needs of children. For example, if a child has a hard time transitioning, the caregiver/teacher can identify strategies to help the child with the transition (individualized warning, job during transition, individual schedule, peer buddy to help, etc.) If a child has a difficult time during a large group activity, the child might be taught to ask for a break; m) Using time-out for behaviors that are persistent and unacceptable. Time-out should only be used in combination with instructional approaches that teach children what to do in place of the behavior problem. (See guidance for time-outs below.) Expectations for children's behavior and the facility's policies regarding their response to behaviors should be written and shared with families and children of appropriate age. Further, the policies should address proactive as well as reactive strategies. Programs should work with families to support their children's appropriate behaviors before it becomes a problem.					
STANDARD 2.2.0.8: Preventing Expulsions, Suspensions, and Other Limitations in Services Child care programs should not expel, suspend, or otherwise limit the amount of services (including denying outdoor time, withholding food, or using food as a reward/punishment) provided to a child or family on the basis of challenging behaviors or a health/safety condition or situation unless the condition or situation meets one of the two exceptions listed in this standard. Expulsion refers to terminating the enrollment of a child or family in the regular group setting because of a challenging behavior or a health condition. Suspension and other limitations in services include all other reductions in the amount of time a child may be in attendance of the regular group setting, either by requiring the child to cease attendance for a particular period of time or reducing the number of days or amount of time that a child may attend.		Not addressed.		DECAL may want to address this specific standard and add it to their rules.	

Requiring a child to attend the program in a special place away from the other children in the regular group setting is included in this definition. Child care programs should have a comprehensive discipline policy that includes an explicit description of alternatives to expulsion for children exhibiting extreme levels of challenging behaviors, and should include the program's protocol for preventing challenging behaviors. These policies should be in writing and clearly articulated and communicated to parents/guardians, staff and others. These policies should also explicitly state how the program plans to use any available internal mental health and other support staff during behavioral crises to eliminate to the degree possible any need for external supports (e.g., local police departments) during crises. Staff should have access to in-service training on both a proactive and as-needed basis on how to reduce the likelihood of problem behaviors escalating to the level of risk for expulsion and how to more effectively manage behaviors throughout the entire class/group. Staff should also have access to in-service training, resources, and child care health consultation to manage children's health conditions in collaboration with parents/guardians and the child's primary care provider. Programs should attempt to obtain access to behavioral or mental health consultation to help establish and maintain environments that will support children's mental well-being and social-emotional health, and have access to such a consultant when more targeted child-specific interventions are needed. Mental health consultation may be obtained from a variety of sources, as described in Standard 1.6.0.3. When children exhibit or engage in challenging behaviors that cannot be resolved easily, as above, staff should: a) Assess the health of the child and the adequacy of the curriculum in meeting the developmental and educational needs of the child; b) Immediately engage the parents/guardians/family in a spirit of collaboration regarding how the child's behaviors may be best handled, including appropriate solutions that have worked at home or in other settings; c) Access an early childhood mental health consultant to assist in developing an effective plan to address the child's challenging behaviors and to assist the child in developing age-appropriate, pro-					

social skills; d) Facilitate, with the family's assistance, a referral for an evaluation for either Part C (early intervention) or Part B (preschool special education), as well as any other appropriate community-based services (e.g., child mental health clinic); e) Facilitate with the family communication with the child's primary care provider (e.g., pediatrician, family medicine provider, etc.), so that the primary care provider can assess for any related health concerns and help facilitate appropriate referrals. The only possible reasons for considering expelling, suspending or otherwise limiting services to a child on the basis of challenging behaviors are: a) Continued placement in the class and/or program clearly jeopardizes the physical safety of the child and/or his/her classmates as assessed by a qualified early childhood mental health consultant AND all possible interventions and supports recommended by a qualified early childhood mental health consultant aimed at providing a physically safe environment have been exhausted; or b) The family is unwilling to participate in mental health consultation that has been provided through the child care program or independently obtain and participate in child mental health assistance available in the community; or c) Continued placement in this class and/or program clearly fails to meet the mental health and/or social-emotional needs of the child as agreed by both the staff and the family AND a different program that is better able to meet these needs has been identified and can immediately provide services to the child. In either of the above three cases, a qualified early childhood mental health consultant, qualified special education staff, and/or qualified community-based mental health care provider should be consulted, referrals for special education services and other community-based services should be facilitated, and a detailed transition plan from this program to a more appropriate setting should be developed with the family and followed. This transition could include a different private or public-funded child care or early education program in the community that is better					

equipped to address the behavioral concerns (e.g., therapeutic preschool programs, Head Start or Early Head Start, prekindergarten programs in the public schools that have access to additional support staff, etc.), or public-funded special education services for infants and toddlers (i.e., Part C early intervention) or preschoolers (i.e., Part B preschool special education). To the degree that safety can be maintained, the child should be transitioned directly to the receiving program. The program should assist parents/guardians in securing the more appropriate placement, perhaps using the services of a local child care resource and referral agency. With parent/guardian permission, the child's primary care provider should be consulted and a referral for a comprehensive assessment by qualified mental health provider and the appropriate special education system should be initiated. If abuse or neglect is suspected, then appropriate child protection services should be informed. Finally, no child should ever be expelled or suspended from care without first conducting an assessment of the safety of alternative arrangements (e.g., Who will care for the child? Will the child be adequately and safely supervised at all times?)					
STANDARD 2.2.0.9: Prohibited Caregiver/ Teacher Behaviors The following behaviors should be prohibited in all child care settings and by all caregivers/teachers: a) The use of corporal punishment. Corporal punishment means punishment inflicted directly on the body including, but not limited to: 1) Hitting, spanking (refers to striking a child with an open hand on the buttocks or extremities with the intention of modifying behavior without causing physical injury), shaking, slapping, twisting, pulling, squeezing, or biting; 2) Demanding excessive physical exercise, excessive rest, or strenuous or bizarre postures; 3) Compelling a child to eat or have in his/her mouth soap, food, spices, or foreign substances; 4) Exposing a child to extremes of temperature. b) Isolating a child in an adjacent room, hallway, closet, darkened area, play area, or any other area where a child cannot be seen or supervised;	**290-2-3-.11 Health, Safety, and Discipline** (3) Discipline. Disciplinary actions used to correct a child's behavior, guidance techniques and any activities in which the children participate or observe at the home shall not be detrimental to the physical or mental health of any child. (a) A provider or a home's employees shall not: 1. Physically or sexually abuse a child, or engage in or permit others to engage in sexually overt conduct in the presence of any child enrolled in the home; or 2. Inflict corporal/physical punishment upon a child; or 3. Shake, jerk, pinch or handle roughly a child; or 4. Verbally abuse or humiliate a child which includes, but is not limited to, the use of threats, profanity, or belittling remarks	Meets to Exceeds.			

c) Binding or tying to restrict movement, such as in a car seat (except when travelling) or taping the mouth; d) Using or withholding food as a punishment or reward; e) Toilet learning/training methods that punish, demean, or humiliate a child; f) Any form of emotional abuse, including rejecting, terrorizing, extended ignoring, isolating, or corrupting a child; g) Any abuse or maltreatment of a child, either as an incident of discipline or otherwise. Any child care program must not tolerate, or in any manner condone, an act of abuse or neglect of a child by an older child, employee, volunteer, or any person employed by the facility or child's family; h) Abusive, profane, or sarcastic language or verbal abuse, threats, or derogatory remarks about the child or child's family; i) Any form of public or private humiliation, including threats of physical punishment; j) Physical activity/outdoor time should not be taken away as punishment.	about a child or his family; or 5. Isolate a child in a dark room, closet, or unsupervised area; or 6. Use mechanical or physical restraints or devices to discipline children; or 7. Use medication to discipline a child or to control children's behavior without written medical authorization issued by a licensed professional and given with the parent's or guardian's written consent. 8. Discipline a child by restricting unreasonably a child from going to the bathroom; or by punishing toileting accidents; or by force feeding a child; or by not feeding a child regularly scheduled meals and/or snacks; or by forcing or withholding naps; or by allowing children to discipline or humiliate other children; or by confining a child for disciplinary purposes to a swing, high chair, infant carrier, walker or jump seat.				
STANDARD 2.3.3.1: Parents'/Guardians' Provision of Information on Their Child's Health and Behavior The facility should ask parents/guardians for information regarding the child's health, nutrition, level of physical activity, and behavioral status upon registration or when there has been an extended gap in the child's attendance at the facility. The child's health record should be updated if s/ he have had any changes in their health or immunization status. Parents/guardians should be encouraged to sign a release of information/agreement so that child care workers can communicate directly with the child's medical home/ primary care provider.	**290-2-3-.08 Children's Records.** (1) The home shall maintain current and updated individual records on each child in care. The home shall maintain the records outlined herein while the child is in care and for a period of one (1) year after such child is no longer in care at the family day care home. Such records shall include: (a) Identifying information (child's name, birth date, parents name, or guardian's name if applicable, home and business addresses, telephone numbers); (b) Name, address and telephone number of persons including child's physician to contact in emergencies; (c) Evidence of age-appropriate	Meets to Exceeds.			

	immunizations, or a signed affidavit certifying that the required immunizations conflict with the religious belief of the parent or guardian or a physician statement that immunization is contraindicated; (d) Written authorization for the child to receive emergency medical treatment when the parent or guardian is not available; (e) Documentation of any medications given as described in rule .11 (1)(e); (f) Record of any allergies and other known medical problems; (g) Description of accidents or serious illnesses occurring while child is in the family day care home, including date , time and condition under which it occurred and the action taken; (h) Parental or guardian agreements for transportation, field trips, swimming and/or other activities away from the home if the child will be participating in these activities; (i) Name of person(s) to whom the child may be released. Such information shall contain the authorized person's address, te lephone numbers , relations hip to child and to parent(s) or guardian, and other identifying information. (j) Documentation that the child has been signed in and signed out of the family day care home at the time of each arrival and departure by the parent, guardian or person(s) authorized by the parent to drop off or pick up the child, which includes at least the following information: child's name , date, drop-off and pick-up times, and initials of parent, guardian or other authorized person, and whic h need not be file d in the child's individual record. The family day care home shall ensure that children are only released to authorized person(s), and the home shall take				

	necessary steps to determine that any such person(s) presenting to pick up a child in care is authorized by the parent(s) or guardian of the child and that person matches the identifying information provided by the parent or guardian.				
STANDARD 3.1.2.1: Routine Health Supervision and Growth Monitoring The facility should require that each child has routine health supervision by the child's primary care provider, according to the standards of the American Academy of Pediatrics (AAP). For all children, health supervision includes routine screening tests, immunizations, and chronic or acute illness monitoring. For children younger than twenty-four months of age, health supervision includes documentation and plotting of sex-specific charts on child growth standards from the World Health Organization (WHO), available at http://www.who.int/child growth/standards/en/, and assessing diet and activity. For children twenty-four months of age and older, sex-specific height and weight graphs should be plotted by the primary care provider in addition to body mass index (BMI), according to the Centers for Disease Control and Prevention (CDC). BMI is classified as underweight (BMI less than 5%), healthy weight (BMI 5%-84%), overweight (BMI 85%-94%), and obese (BMI equal to or greater than 95%). Follow-up visits with the child's primary care provider that include a full assessment and laboratory evaluations should be scheduled for children with weight for length greater than 95% and BMI greater than 85%. School health services can meet this standard for school-age children in care if they meet the AAP's standards for school-age children and if the results of each child's examinations are shared with the caregiver/teacher as well as with the school health system. With parental/guardian consent, pertinent health information should be exchanged among the child's routine source of health care and all participants in the child's care, including any school health		Not addressed.		DECAL may want to address this specific standard and add it to their rules.	

program involved in the care of the child.					
STANDARD 3.1.3.1: Active Opportunities for Physical Activity The facility should promote children's active play every day. Children should have ample opportunity to do moderate to vigorous activities such as running, climbing, dancing, skipping, and jumping. All children, birth to six years, should participate daily in: a) Two to three occasions of active play outdoors, weather permitting; b) Two or more structured or caregiver/teacher/adult-led activities or games that promote movement over the course of the day—indoor or outdoor; c) Continuous opportunities to develop and practice age-appropriate gross motor and movement skills. The total time allotted for outdoor play and moderate to vigorous indoor or outdoor physical activity can be adjusted for the age group and weather conditions. a) Outdoor play: 1) Infants (birth to twelve months of age) should be taken outside two to three times per day, as tolerated. There is no recommended duration of infants' outdoor play; 2) Toddlers (twelve months to three years) and preschoolers (three to six years) should be allowed sixty to ninety total minutes of outdoor play. These outdoor times can be curtailed somewhat during adverse weather conditions in which children may still play safely outdoors for shorter periods, but should increase the time of indoor activity, so the total amount of exercise should remain the same; b) Total time allotted for moderate to vigorous activities: 1) Toddlers should be allowed sixty to ninety minutes per eight-hour day for moderate to vigorous physical activity, including running; 2) Preschoolers should be allowed ninety to one hundred and twenty minutes per eight-hour day. Infants should have supervised tummy time every day	**290-2-3-.09 Children's Activities.** (1) The family day care home shall provide a variety of daily activities appropriate for the children's chronological ages and developmental levels. Children with special needs shall be integrated into the activities provided by the family day care home unless contraindicated medically or by parental agreement. Activities shall be planned for each group to allow for: (a) Indoor and outdoor play; (b) A balance of quiet and active periods; (c) A balance of supervised free choice and caregiver-directed activities; (d) Individual, small group, and large group activities; (e) Large muscle activities, such as, but not limited to, running, riding, climbing, balancing, jumping, throwing, or digging; (f) Small muscle activities , such as, but not limited to, building with blocks or construction toys, use of puzzles, nesting or stacking toys, pegs, lacing, sorting beads, or clay; (g) Language experiences, such as, but not limited to, listening, talking, rhymes, finger plays, stories, use of film strips, recordings or flannel boards; (h) Arts and crafts, such as, but not limited to, painting, coloring, cutting, or pasting; (i) Dramatic play, such as, but not limited to, play in a home center, with dolls, puppets, or dress up; (j) Rhythm and music, such as, but not limited to, listening, singing, dancing, or making music; and (k) Nature and science experiences, such as, but not limited to, measuring, pouring, activities related to the "world around us" such as nature walks , plants, leaves or	Partially Meets.	This rule has some of the basic elements contained in the Stepping Stones standard but not the details (number of occasions, etc..) and in some cases time frames are not adequate, such as: infants should not be seated for more than fifteen minutes at a time.	DECAL should review the specific language of the Stepping Stones standard in revising this rule.	

when they are awake. Beginning on the first day at the early care and education program, caregivers/teachers should interact with an awake infant on their tummy for short periods of time (three to five minutes), increasing the amount of time as the infant shows s/he enjoys the activity. Time spent outdoors has been found to be a strong, consistent predictor of children's physical activity. Children can accumulate opportunities for activity over the course of several shorter segments of at least ten minutes each. Because structured activities have been shown to produce higher levels of physical activity in young children, it is recommended that caregivers/teachers incorporate two or more short structured activities (five to ten minutes) or games daily that promote physical activity. Opportunities to be actively enjoying physical activity should be incorporated into part-time programs by prorating these recommendations accordingly, i.e., twenty minutes of outdoor play for every three hours in the facility. Active play should never be withheld from children who misbehave (e.g., child is kept indoors to help another caregiver/ teacher while the rest of the children go outside). However, children with out-of-control behavior may need five minutes or less to calm themselves or settle down before resuming cooperative play or activities. Infants should not be seated for more than fifteen minutes at a time, except during meals or naps. Infant equipment such as swings, stationary activity centers (ex. exersaucers), infant seats (ex. bouncers), molded seats, etc. if used should only be used for short periods of time. A least restrictive environment should be encouraged at all times. Children should have adequate space for both inside and outside play.	weather, or experiences in using the five senses through sensory play. (2) Children shall be helped to develop skills in all areas (washing, dressing, toileting, etc.) appropriate to the age and ability of the child. (3) Children shall spend some time of each day outside when the children's health and the weather permits. (4) There shall be a supervised nap period during the day for preschool age children. (5) Infants and toddlers shall not routinely be left in cribs , or playpens except for rest or sleep. (6) The use of entertainment media , such as television programs or video tapes , and computer games shall be limited to programs , tapes, and software that are produced for the benefit of audiences comprised of young children. Such uses of entertainment media shall be used only in addition to other activities , shall not be the primary source of children's activities , and should be limited to no more than two hours daily. (7) The provider shall not engage in or allow children or other adults to engage in activities that could be detrimental to a child's health or well-being such as, but not limited to, horse play, rough play, wrestling, and picking up a child in a manner that could cause injury.				
STANDARD 3.1.4.1: Safe Sleep Practices and SIDS/Suffocation Risk Reduction Facilities should develop a written policy that describes the practices to be used to promote safe sleep when infants are napping or sleeping. The policy should explain that these practices aim to reduce the risk of sudden infant death syndrome (SIDS) or suffocation death and other infant deaths that could occur when an infant is in a crib or asleep.	**290-2-3-.19 Infant-Sleeping Safety Requirements.** In order to reduce the risk of Sudden Infant Death Syndrome (SIDS), staff shall put an infant to sleep on the infant's back unless the home has been provided a physician's written statement authorizing another sleep position for that particular infant. The infant shall be placed for sleeping on a	Partially meets.	This rule contains the basic elements of the Stepping Stones standard but more specific citations to the US Consumer Product Safety Commission (CPSC) and ASTM standards and guidelines are not present.	DECAL should add the specific wording regarding cribs meeting the standards and guidelines reviewed/approved by the CPSC and ASTM.	

All staff, parents/guardians, volunteers and others approved to enter rooms where infants are cared for should receive a copy of the Safe Sleep Policy and additional educational information and training on the importance of consistent use of safe sleep policies and practices before they are allowed to care for infants (i.e., first day of employment/volunteering/ subbing). Documentation that training has occurred and that these individuals have received and reviewed the written policy should be kept on file. All staff, parents/guardians, volunteers and others who care for infants in the child care setting should follow these required safe sleep practices as recommended by the American Academy of Pediatrics (AAP) (1): a) Infants up to twelve months of age should be placed for sleep in a supine position (wholly on their back) for every nap or sleep time unless the infant's primary care provider has completed a signed waiver indicating that the child requires an alternate sleep position; b) Infants should be placed for sleep in safe sleep environments; which includes: a firm crib mattress covered by a tight-fitting sheet in a safety-approved crib (the crib should meet the standards and guidelines reviewed/approved by the U.S. Consumer Product Safety Commission [CPSC] and ASTM International [ASTM]), no monitors or positioning devices should be used unless required by the child's primary care provider, and no other items should be in a crib occupied by an infant except for a pacifier; c) Infants should not nap or sleep in a car safety seat, bean bag chair, bouncy seat, infant seat, swing, jumping chair, play pen or play yard, highchair, chair, futon, or any other type of furniture/equipment that is not a safety-approved crib (that is in compliance with the CPSC and ASTM safety standards); d) If an infant arrives at the facility asleep in a car safety seat, the parent/guardian or caregiver/teacher should immediately remove the sleeping infant from this seat and place them in the supine position in a safe sleep environment (i.e., the infant's assigned crib); e) If an infant falls asleep in any place that is not a safe sleep environment, staff should immediately	firm, tight-fitting mattress in a sturdy and safe crib. If the crib has side bars, the bars will be no more than two and three eighths inches (2 3/8") apart. Any crib used for sleeping shall have a tight-fitting bottom crib sheet with no pillows, quilts, comforters, bumper pads, sheepskins, stuffed toys, or other soft items in the crib. If a blanket is required for the comfort of the infant, the infant's feet shall be placed at the foot of the crib and the infant shall be covered with the blanket only to chest level with the blanket tucked firmly under the crib mattress. The infant's sleeping area shall be maintained within a temperature range of sixty-five (65) to eighty-five (85) degrees depending upon the season. When an infant can easily turn over onto his or her stomach, staff shall continue to put the infant to sleep initially on the infant's back but allow the infant to roll over onto his or her stomach as the infant prefers. Positioning devices that restrict an infant's movement in the crib shall not be used unless a physician's written statement authorizing its use is provided for that particular infant.				

move the infant and place them in the supine position in their crib; f) Only one infant should be placed in each crib (stackable cribs are not recommended); g) Soft or loose bedding should be kept away from sleeping infants and out of safe sleep environments. These include, but are not limited to: bumper pads, pillows, quilts, comforters, sleep positioning devices, sheepskins, blankets, flat sheets, cloth diapers, bibs, etc. Also, blankets/items should not be hung on the sides of cribs. Swaddling infants when they are in a crib is not necessary or recommended, but rather one-piece sleepers should be used; h) Toys, including mobiles and other types of play equipment that are designed to be attached to any part of the crib should be kept away from sleeping infants and out of safe sleep environments; i) When caregivers/teachers place infants in their crib for sleep, they should check to ensure that the temperature in the room is comfortable for a lightly clothed adult, check the infants to ensure that they are comfortably clothed (not overheated or sweaty), and that bibs, necklaces, and garments with ties or hoods are removed (clothing sacks or other clothing designed for sleep can be used in lieu of blankets); j) Infants should be directly observed by sight and sound at all times, including when they are going to sleep, are sleeping, or are in the process of waking up; k) Bedding should be changed between children, and if mats are used, they should be cleaned between uses. The lighting in the room must allow the caregiver/teacher to see each infant's face, to view the color of the infant's skin, and to check on the infant's breathing and placement of the pacifier (if used). A caregiver/teacher trained in safe sleep practices and approved to care for infants should be present in each room at all times where there is an infant. This caregiver/teacher should remain alert and should actively supervise sleeping infants in an ongoing manner. Also, the caregiver/teacher should check to ensure that the infant's head remains uncovered and re-adjust clothing as needed. The construction and use of sleeping rooms for infants					

separate from the infant group room is not recommended due to the need for direct supervision. In situations where there are existing facilities with separate sleeping rooms, facilities should develop a plan to modify room assignments and/or practices to eliminate placing infants to sleep in separate rooms. Facilities should be aware of the current recommendation of the AAP about pacifier use (1). If pacifiers are allowed, facilities should have a written policy that describes relevant procedures and guidelines. Pacifier use outside of a crib in rooms and programs where there are mobile infants or toddlers is not recommended.					
STANDARD 3.2.1.4: Diaper Changing Procedure The following diaper changing procedure should be posted in the changing area, should be followed for all diaper changes, and should be used as part of staff evaluation of caregivers/teachers who diaper. The signage should be simple and should be in multiple languages if caregivers/ teachers who speak multiple languages are involved in diapering. All employees who will diaper should undergo training and periodic assessment of diapering practices. Caregivers/teachers should never leave a child unattended on a table or countertop, even for an instant. A safety strap or harness should not be used on the diaper changing table. If an emergency arises, caregivers/teachers should bring any child on an elevated surface to the floor or take the child with them. An EPA-registered disinfectant suitable for the surface material that is being disinfected should be used. If an EPA-registered product is not available, then household bleach diluted with water is a practical alternative. All cleaning and disinfecting solutions should be stored to be accessible to the caregiver/teacher but out of reach of any child. Please refer to Appendix J, Selecting an Appropriate Sanitizer or Disinfectant. Step 1: Get organized. Before bringing the child to the diaper changing area, perform hand hygiene, gather and bring supplies to the diaper changing area: a) Non-absorbent paper liner large enough to cover the changing surface from the child's shoulders to beyond the child's feet; b) Unused diaper, clean clothes (if you need them);		Not addressed.		DECAL may want to address this specific standard and add it to their rules.	

c) Wipes for cleaning the child's genitalia and buttocks removed from the container or dispensed so the container will not be touched during diaper changing; d) A wet cloth or paper towel; e) A plastic bag for any soiled clothes or cloth diapers; f) Disposable gloves, if you plan to use them (put gloves on before handling soiled clothing or diapers) and remove them before handling clean diapers and clothing; g) A thick application of any diaper cream (e.g., zinc oxide ointment), when appropriate, removed from the container to a piece of disposable material such as facial or toilet tissue. Step 2: Carry the child to the changing table, keeping soiled clothing away from you and any surfaces you cannot easily clean and sanitize after the change. a) Always keep a hand on the child; b) If the child's feet cannot be kept out of the diaper or from contact with soiled skin during the changing process, remove the child's shoes and socks so the child does not contaminate these surfaces with stool or urine during the diaper changing. Step 3: Clean the child's diaper area. a) Place the child on the diaper change surface and unfasten the diaper, but leave the soiled diaper under the child; b) If safety pins are used, close each pin immediately once it is removed and keep pins out of the child's reach (never hold pins in your mouth); c) Lift the child's legs as needed to use disposable wipes to clean the skin on the child's genitalia and buttocks and prevent recontamination from a soiled diaper. If there is a need to clean between the labia of an infant girl, use only a wet cloth or paper towel. Remove stool and urine from front to back and use a fresh wipe each time you swipe. Put the soiled wipes into the soiled diaper or directly into a plastic-lined, hands-free covered can. Step 4: Remove the soiled diaper and clothing without contaminating any surface not already in contact with stool					

or urine. a) Fold the soiled surface of the diaper inward; b) Put soiled disposable diapers in a covered, plastic-lined, hands-free covered can. If reusable cloth diapers are used, put the soiled cloth diaper and its contents (without emptying or rinsing) in a plastic bag or into a plastic-lined, hands-free covered can to give to parents/guardians or laundry service; c) Put soiled clothes in a plastic-lined, hands-free plastic bag; d) If gloves were used, remove them using the proper technique (see Appendix D) and put them into a plastic-lined, hands-free covered can; e) Whether or not gloves were used, use a disposable antibacterial wipe or alcohol-based hand sanitizer to clean the surfaces of the caregiver/teacher's hands and an application to clean the child's hands, and put the wipes, if used, into the plastic-lined, hands-free covered can. Allow sanitized hands to dry completely before proceeding; f) Check for spills under the child. If there are any, use the paper that extends under the child's feet to fold over the soiled area so a fresh, unsoiled paper surface is now under the child's buttocks. Step 5: Put on a clean diaper and dress the child. a) Slide a fresh diaper under the child; b) Use a facial or toilet tissue or wear clean disposable glove to apply any necessary diaper creams, discarding the tissue or glove in a covered, plastic-lined, hands-free covered can; c) Note and plan to report any skin problems such as redness, skin cracks, or bleeding; d) Fasten the diaper; if pins are used, place your hand between the child and the diaper when inserting the pin. Step 6: Wash the child's hands and return the child to a supervised area. a) Use soap and warm water, between 60°F and 120°F, at a sink to wash the child's hands, if you can. Step 7: Clean and disinfect the diaper-changing surface. a) Dispose of the disposable paper liner used on the diaper changing surface in a plastic-lined, hands-					

free covered can; b) If clothing was soiled, securely tie the plastic bag used to store the clothing and send home; c) Remove any visible soil from the changing surface with a water saturated disposable paper towel or wipe; d) Wet the entire changing surface with a disinfectant that is appropriate for the surface material you are treating. Follow the manufacturer's instructions for use; e) Put away the disinfectant. Some types of disinfectants may require rinsing the change table surface with fresh water afterwards. Step 8: Perform hand hygiene according to the procedure in Standard 3.2.2.2 and record the diaper change in the child's daily log. a) In the daily log, record what was in the diaper and any problems (such as a loose stool, an unusual odor, blood in the stool, or any skin irritation), and report as necessary.					
STANDARD 3.2.2.1: Situations that Require Hand Hygiene All staff, volunteers, and children should follow the procedure in Standard 3.2.2.2 for hand hygiene at the following times: a) Upon arrival for the day, after breaks, or when moving from one child care group to another; b) Before and after: 1) Preparing food or beverages; 2) Eating, handling food, or feeding a child; 3) Giving medication or applying a medical ointment or cream in which a break in the skin (e.g., sores, cuts, or scrapes) may be encountered; 4) Playing in water (including swimming) that is used by more than one person; 5) Diapering; c) After: 1) Using the toilet or helping a child use a toilet; 2) Handling bodily fluid (mucus, blood, vomit), from sneezing, wiping and blowing noses, from mouths, or from sores;	**290-2-3-.11 Health, Safety, and Discipline** (j) Personnel shall wash their hands with liquid soap and warm running water: 1. Immediately before and after each diaper change; 2. Immediately upon the first child's arrival in the home for care and upon re-entering the home after outside play; 3. Before and after dispensing oral medications and applying topical medications, ointments, creams or lotions, handling and preparing food, eating, drinking, preparing bottles, feeding each child, assisting children with eating and drinking; and 4. After toileting or helping children with toileting, using tobacco products, handling garbage and organic waste, touching animals or pets, handling bodily fluids, such as, but not limited to, mucus, saliva, vomit or blood, or contamination by any	Meets.			

3) Handling animals or cleaning up animal waste; 4) Playing in sand, on wooden play sets, and outdoors; 5) Cleaning or handling the garbage. Situations or times that children and staff should perform hand hygiene should be posted in all food preparation, hand hygiene, diapering, and toileting areas.	other means. (k) Children's hands shall be washed with liquid soap and warm running water: 1. Immediately upon arrival for the day and re-entering the child care area after outside play; 2. Before and after eating meals and snacks, handling or touching food, and playing in water; 3. After toileting and diapering, playing in sand, touching animals or pets, contact with bodily fluids such as, but not limited to, mucus, saliva, vomit or blood, and after contamination by any other means; and 4. Washcloth handwashing is permitted for infants when the infant is too heavy to hold for handwashing or cannot stand safely to wash hands at a sink and for children with special needs who are not capable of washing their own hands. An individual washcloth shall be used only once for each child before laundering.				
STANDARD 3.2.2.2: Handwashing Procedure Children and staff members should wash their hands using the following method: a) Check to be sure a clean, disposable paper (or single-use cloth) towel is available; b) Turn on warm water, between 60°F and 120°F, to a comfortable temperature; c) Moisten hands with water and apply soap (not antibacterial) to hands; d) Rub hands together vigorously until a soapy lather appears, hands are out of the water stream, and continue for at least twenty seconds (sing Happy Birthday silently twice) (2). Rub areas between fingers, around nailbeds, under fingernails, jewelry, and back of hands. Nails should be kept short; acrylic nails should not worn (3); e) Rinse hands under running water, between 60°F and 120°F, until they are free of soap and dirt. Leave the water running while drying hands;		Not addressed.		DECAL may want to address this specific standard and add it to their rules.	

f) Dry hands with the clean, disposable paper or single use cloth towel; g) If taps do not shut off automatically, turn taps off with a disposable paper or single use cloth towel; h) Throw the disposable paper towel into a lined trash container; or place single-use cloth towels in the laundry hamper; or hang individually labeled cloth towels to dry. Use hand lotion to prevent chapping of hands, if desired. The use of alcohol based hand sanitizers is an alternative to traditional handwashing with soap and water by children over twenty-four months of age and adults on hands that are not visibly soiled. A single pump of an alcohol-based sanitizer should be dispensed. Hands should be rubbed together, distributing sanitizer to all hand and finger surfaces and hands should be permitted to air dry. Situations/times that children and staff should wash their hands should be posted in all handwashing areas. Use of antimicrobial soap is not recommended in child care settings. There are no data to support use of antibacterial soaps over other liquid soaps. Children and staff who need to open a door to leave a bath-room or diaper changing area should open the door with a disposable towel to avoid possibly re-contaminating clean hands. If a child can not open the door or turn off the faucet, they should be assisted by an adult.					
STANDARD 3.2.2.3: Assisting Children with Hand Hygiene Caregivers/teachers should provide assistance with hand-washing at a sink for infants who can be safely cradled in one arm and for children who can stand but not wash their hands independently. A child who can stand should either use a child-height sink or stand on a safety step at a height at which the child's hands can hang freely under the running water. After assisting the child with handwashing, the staff member should wash his or her own hands. Hand hygiene with an alcohol-based sanitizer is an alternative to handwashing with soap and water by children over twenty-four months of age and adults when there is no visible soiling of hands.	**290-2-3-.11 Health, Safety, and Discipline** (k) Children's hands shall be washed with liquid soap and warm running water: 1. Immediately upon arrival for the day and re-entering the child care area after outside play; 2. Before and after eating meals and snacks, handling or touching food, and playing in water; 3. After toileting and diapering, playing in sand, touching animals or pets, contact with bodily fluids such as, but not limited to, mucus, saliva, vomit or blood, and after contamination by any other means; and	Partially meets.	There appears to be a discrepancy in that the rule suggests using a washcloth and does not address the use of an alcohol-based sanitizer as an alternative to hand-washing with soap and water.	May want to consider the use of an alcohol-based sanitizer as an alternative to hand-washing with soap and water.	

	4. Washcloth handwashing is permitted for infants when the infant is too heavy to hold for handwashing or cannot stand safely to wash hands at a sink and for children with special needs who are not capable of washing their own hands. An individual washcloth shall be used only once for each child before laundering.				
STANDARD 3.2.3.4: Prevention of Exposure to Blood and Body Fluids Child care facilities should adopt the use of Standard Precautions developed for use in hospitals by The Centers for Disease Control and Prevention (CDC). Standard Precautions should be used to handle potential exposure to blood, including blood-containing body fluids and tissue discharges, and to handle other potentially infectious fluids. In child care settings: a) Use of disposable gloves is optional unless blood or blood containing body fluids may contact hands. Gloves are not required for feeding human milk, cleaning up of spills of human milk, or for diapering; b) Gowns and masks are not required; c) Barriers to prevent contact with body fluids include moisture-resistant disposable diaper table paper, disposable gloves, and eye protection. Caregivers/teachers are required to be educated regarding Standard Precautions to prevent transmission of bloodborne pathogens before beginning to work in the facility and at least annually thereafter. Training must comply with requirements of the Occupational Safety and Health Administration (OSHA). Procedures for Standard Precautions should include: a) Surfaces that may come in contact with potentially infectious body fluids must be disposable or of a material that can be disinfected. Use of materials that can be sterilized is not required. b) The staff should use barriers and techniques that: 1) Minimize potential contact of mucous membranes or openings in skin to blood or other potentially infectious body fluids and	**290-2-3-.11 Health, Safety, and Discipline** The home must also maintain written directions for the use of universal precautions for handling blood and bodily fluids. The directions on the use of universal precautions must be kept with the first aid kit at all times. Personnel shall wash their hands with liquid soap and warm running water: 1. Immediately before and after each diaper change; 2. Immediately upon the first child's arrival in the home for care and upon re-entering the home after outside play; 3. Before and after dispensing oral medications and applying topical medications, ointments, creams or lotions, handling and preparing food, eating, drinking, preparing bottles, feeding each child, assisting children with eating and drinking; and 4. After toileting or helping children with toileting, using tobacco products, handling garbage and organic waste, touching animals or pets, handling bodily fluids, such as, but not limited to, mucus, saliva, vomit or blood, or contamination by any other means. (k) Children's hands shall be washed with liquid soap and warm running water: 1. Immediately upon arrival for the day	Partially meets.	No reference to CDC Standard Precautions.	DECAL may want to add this reference to CDC Standard Precautions.	

tissue discharges; and 2) Reduce the spread of infectious material within the child care facility. Such techniques include avoiding touching surfaces with potentially contaminated materials unless those surfaces are disinfected before further contact occurs with them by other objects or individuals. c) When spills of body fluids, urine, feces, blood, saliva, nasal discharge, eye discharge, injury or tissue discharges occur, these spills should be cleaned up immediately, and further managed as follows: 1) For spills of vomit, urine, and feces, all floors, walls, bathrooms, tabletops, toys, furnishings and play equipment, kitchen counter tops, and diaper-changing tables in contact should be cleaned and disinfected as for the procedure for diaper changing tables in Standard 3.2.1.4, Step 7; 2) For spills of blood or other potentially infectious body fluids, including injury and tissue discharges, the area should be cleaned and disinfected. Care should be taken and eye protection used to avoid splashing any contaminated materials onto any mucus membrane (eyes, nose, mouth); 3) Blood-contaminated material and diapers should be disposed of in a plastic bag with a secure tie; 4) Floors, rugs, and carpeting that have been contaminated by body fluids should be cleaned by blotting to remove the fluid as quickly as possible, then disinfected by spot-cleaning with a detergent-disinfectant. Additional cleaning by shampooing or steam cleaning the contaminated surface may be necessary. Caregivers/teachers should consult with local health departments for additional guidance on cleaning contaminated floors, rugs, and carpeting. Prior to using a disinfectant, clean the surface with a de-tergent and rinse well with water. Facilities should follow the manufacturer's instruction for preparation and use of disinfectant. If blood or bodily fluids enter a mucous membrane (eyes, nose, mouth) the following procedure	and re-entering the child care area after outside play; 2. Before and after eating meals and snacks, handling or touching food, and playing in water; 3. After toileting and diapering, playing in sand, touching animals or pets, contact with bodily fluids such as, but not limited to, mucus, saliva, vomit or blood, and after contamination by any other means				

should occur. Flush the exposed area thoroughly with water. The goal of washing or flushing is to reduce the amount of the pathogen to which an exposed individual has contact. The optimal length of time for washing or flushing an exposed area is not known. Standard practice for managing mucous membrane(s) exposures to toxic substances is to flush the affected area for at least fifteen to twenty minutes. In the absence of data to support the effectiveness of shorter periods of flushing it seems prudent to use the same fifteen to twenty minute standard following exposure to bloodborne pathogens.					
STANDARD 3.4.1.1: Use of Tobacco, Alcohol, and Illegal Drugs Tobacco use, alcohol, and illegal drugs should be prohibited on the premises of the program (both indoor and outdoor environments) and in any vehicles used by the program at all times. Caregivers/teachers should not use tobacco, alcohol, or illegal drugs off the premises during the child care program's paid time including break time.	**290-2-3-.11 Health, Safety, and Discipline** (l)When children are present for care, providers, employees, and any other persons shall not smoke or use tobacco except in areas which are totally separated from areas used for child care. If smoking occurs in other areas of the home, the provider shall so advise parent or guardian.	Meets.			
STANDARD 3.4.3.1: Emergency Procedures When an immediate emergency medical response is required, the following emergency procedures should be utilized: a) First aid should be employed and an emergency medical response team should be called such as 9-1-1 and/or the poison center if a poison emergency (1-800-222-1222); b) The program should implement a plan for emergency transportation to a local emergency medical facility; c) The parent/guardian or parent/guardian's emergency contact person should be called as soon as practical; d) A staff member should accompany the child to the hospital and will stay with the child until the parent/ guardian or emergency contact person arrives. Child to staff ratio must be maintained, so staff may need to be called in to maintain the required ratio.	**290-2-3-.11 Health, Safety, and Discipline** (a) A home shall have a written plan for handling emergencies, including but not limited to fire, severe weather, loss of electrical power or water, and death, serious injury or loss of a child, which may occur at the home. No home personnel shall impede in any way the delivery of emergency care or services to a child by licensed or certified emergency health care professionals. **290-2-3-.08 Children's Records** 10. Identification of others providing care. The provider must inform the parents or guardian of children in care of the names of any caregiver and their responsibilities, and the names of the persons who would be called upon in an emergency;	Partially meets.	The rule specifies a written plan for emergency medical services but does not specify the procedures.	DECAL should adopt the emergency procedures for an emergency medical response as outlined in Stepping Stones.	

Programs should develop contingency plans for emergencies or disaster situations when it may not be possible or feasible to follow standard or previously agreed upon emergency procedures (see also Standard 9.2.4.3, Disaster Planning, Training, and Communication). Children with known medical conditions that might involve emergent care require a Care Plan created by the child's primary care provider. All staff need to be trained to manage an emergency until emergency medical care becomes available.					
STANDARD 3.4.4.1: Recognizing and Reporting Suspected Child Abuse, Neglect, and Exploitation Each facility should have a written policy for reporting child abuse and neglect. Caregivers/teachers are mandated reporters of child abuse and neglect. The facility should report to the child abuse reporting hotline, department of social services, child protective services, or police as required by state and local laws, in any instance where there is reasonable cause to believe that child abuse and neglect has occurred. Every staff person should be oriented to what and how to report. Phone numbers and reporting system as required by state or local agencies should be clearly posted by every phone. Caregivers/teachers should receive initial and ongoing training to assist them in preventing child abuse and neglect and in recognizing signs of child abuse and neglect. Programs are encouraged to partner with primary care providers, child care health consultants and/or child protection advocates to provide training and to be available for consultation. Parents/guardians should be notified upon enrollment of the facility's child abuse and neglect reporting requirement and procedures.	**290-2-3-.14 Reporting.** (1) Within twenty-four (24) hours or the next work day, the home shall report the following to the Child Care Licensing Office: (2) Any suspected incident of child abuse, neglect or deprivation shall be reported to the local county Department of Family and Children Services in accordance with O.C.G.A. Sec. 19-7-5, and to the Child Care Licensing Office. **290-2-3-.07 Staffing and Supervision** The ten clock hours of training shall be chosen from the following fields: (c) Child Abuse and Neglect: including identification and reporting, and meeting the needs of abused and/or neglected children	Partially meets.	The rule covers staff training but does not have a requirement for a written policy or phone numbers posted by the phone.	DECAL may want to add the wording from the Stepping Stones standard.	
STANDARD 3.4.4.3: Preventing and Identifying Shaken Baby Syndrome/Abusive Head Trauma All child care facilities should have a policy and procedure to identify and prevent shaken baby syndrome/abusive head trauma. All caregivers/teachers who are in direct contact with children including substitute		Not addressed.		DECAL may want to address this specific standard and add it to their rules.	

caregivers/teachers and volunteers, should receive training on preventing shaken baby syndrome/abusive head trauma, recognition of potential signs and symptoms of shaken baby syndrome/abusive head trauma, strategies for coping with a crying, fussing or distraught child, and the development and vulnerabilities of the brain in infancy and early childhood.					
STANDARD 3.4.4.4: Care for Children Who Have Been Abused/Neglected Caregivers/teachers should have access to specialized training and expert advice for children with behavioral ab-normalities related to abuse or neglect are enrolled.	**290-2-3-.07 Staffing and Supervision** The ten clock hours of training shall be chosen from the following fields: (c) Child Abuse and Neglect: including identification and reporting, and meeting theneeds of abused and/or neglected children	Partially meets.	Rule addresses training but not expert advice.	DECAL may want to add the additional working related to expert advice.	
STANDARD 3.4.4.5: Facility Layout to Reduce Risk of Child Abuse and Neglect The physical layout of facilities should be arranged so that there is a high level of visibility in the inside and outside areas as well as diaper changing areas and toileting areas used by children. All areas should be viewed by at least one other adult in addition to the caregiver/teacher at all times when children are in care. For center-based programs, rooms should be designed so that there are windows to the hallways to keep classroom activities from being too private. Ideally each area of the facility should have two adults at all times. Such an arrangement reduces the risk of child abuse and neglect and the likelihood of extended periods of time in isolation for individual caregivers/teachers with children, especially in areas where children may be partially undressed or in the nude. NOT FOUND		Not addressed.		DECAL may want to address this specific standard and add it to their rules.	
STANDARD 3.5.0.1: Care Plan for Children with Special Health Care Needs Any child who meets these criteria should have a Routine and Emergent Care Plan completed by their primary care provider in their medical home. There should be:	**290-2-3-.09 Children's Activities.** (1) The family day care home shall provide a variety of daily activities appropriate for the children's chronological ages and developmental levels. Children with special needs shall be integrated into	Does not Meet.	No Routine and Emergent Care Plan mentioned.	Need to add reference to Care Plan.	

a) A list of the child's diagnosis/diagnoses; b) Contact information for the primary care provider and any relevant sub-specialists (i.e., endocrinologists, oncologists, etc.); c) Medications to be administered on a scheduled basis; d) Medications to be administered on an emergent basis with clearly stated parameters, signs, and symptoms that warrant giving the medication written in lay language; e) Procedures to be performed; f) Allergies; g) Dietary modifications required for the health of the child; h) Activity modifications; i) Environmental modifications; j) Stimulus that initiates or precipitates a reaction or series of reactions (triggers) to avoid; k) Symptoms for caregiver/teachers to observe; l) Behavioral modifications; m) Emergency response plans – both if the child has a medical emergency and special factors to consider in programmatic emergency, like a fire; n) Suggested special skills training and education for staff. The Care Plan should be updated after every hospitalization or significant change in health status of the child. The Care Plan is completed by the primary care provider in the medical home with input from parents/guardians, and it is implemented in the child care setting. The child care health consultant should be involved to assure adequate information, training, and monitoring is available for child care staff.	the activities provided by the family day care home unless contraindicated medically or by parental agreement.				
STANDARD 3.5.0.2: Caring for Children Who Require Medical Procedures A facility that enrolls children who require the following medical procedures: tube feedings, endotracheal suctioning, supplemental oxygen, postural drainage, or catheterization daily (unless the child requiring catheterization can perform this function on his/her own), checking blood sugars or any other special medical procedures performed routinely, or who might require special procedures on an urgent basis, should receive a written plan of care from the primary care provider who		Not addressed.		DECAL may want to address this specific standard and add it to their rules.	

prescribed the special treatment (such as a urologist for catheterization). Often, the child's primary care provider may be able to provide this information. This plan of care should address any special preparation to perform routine and/or urgent procedures (other than those that might be required in an emergency for any typical child, such as cardiopulmonary resuscitation [CPR]). This plan of care should include instructions for how to receive training in performing the procedure, performing the procedure, a description of common and uncommon complications of the procedure, and what to do and who to notify if complications occur. Specific/relevant training for the child care staff should be provided by a qualified health care professional in accordance with state practice acts. Facilities should follow state laws where such laws require RN's or LPN's under RN supervision to perform certain medical procedures. Updated, written medical orders are required for nursing procedures.					
STANDARD 3.6.1.1: Inclusion/Exclusion/ Dismissal of Children **Preparing for managing illness:** Caregivers/teachers should: a) Encourage all families to have a backup plan for child care in the event of short or long term exclusion; b) Review with families the inclusion/exclusion criteria and clarify that the program staff (not the families) will make the final decision about whether children who are ill may stay based on the program's inclusion/ exclusion criteria and their ability to care for the child who is ill without compromising the care of other children in the program; c) Develop, with a child care health consultant, protocols and procedures for handling children's illnesses, including care plans and an inclusion/ exclusion policy; d) Request the primary care provider's note to readmit a child if the primary care provider's advice is needed to determine whether the child is a health risk to others, or if the primary care	**290-2-3-.11 Health, Safety, and Discipline.** (1) Health. (a) The Department's current communicable disease chart of recommendations for exclusion of sick children from the home and their readmission shall be followed	Meets	DECAL has a current communicable disease chart.	DECAL should review the Dept's current communicable disease chart for specific content to make sure this standard is fully met.	

provider's guidance is needed about any special care the child requires (1); e) Rely on the family's description of the child's behavior to determine whether the child is well enough to return, unless the child's status is unclear from the family's report. Daily health checks as described in Standard 3.1.1.1 should be performed upon arrival of each child each day. Staff should objectively determine if the child is ill or well. Staff should determine which children with mild illnesses can remain in care and which need to be excluded. Staff should notify the parent/guardian when a child develops new signs or symptoms of illness. Parent/guardian notification should be immediate for emergency or urgent issues. Staff should notify parents/guardians of children who have symptoms that require exclusion and parents/guardians should remove the child from the child care setting as soon as possible. For children whose symptoms do not require exclusion, verbal or written notification of the parent/ guardian at the end of the day is acceptable. Most conditions that require exclusion do not require a primary care provider visit before reentering care. **Conditions/symptoms that do not require exclusion:** a) Common colds, runny noses (regardless of color or consistency of nasal discharge); b) A cough not associated with a infectious disease (such as pertussis) or a fever; c) Watery, yellow or white discharge or crusting eye discharge without fever, eye pain, or eyelid redness; d) Yellow or white eye drainage that is not associated with pink or red conjunctiva (i.e., the whites of the eyes); e) Pink eye (bacterial conjunctivitis) indicated by pink or red conjunctiva with white or yellow eye mucous drainage and matted eyelids after sleep. Parents/ guardians should discuss care of this condition with their child's primary care provider, and follow the primary care provider's advice. Some primary care providers do not think it is necessary to examine the child if the discussion with the parents/guardians suggests that the condition is likely to be self-limited. If two unrelated children in the same program have conjunctivitis, the organism causing the					

conjunctivitis may have a higher risk for transmission and a child health care professional should be consulted; f) Fever without any signs or symptoms of illness in children who are older than six months regardless of whether acetaminophen or ibuprofen was given. Fever (temperature above 101°F [38.3°C] orally, above 102°F [38.9°C] rectally, or 100°F [37.8°C] or higher taken axillary [armpit] or measured by an equivalent method) is an indication of the body's response to something, but is neither a disease nor a serious problem by itself. Body temperature can be elevated by overheating caused by overdressing or a hot environment, reactions to medications, and response to infection. If the child is behaving normally but has a fever of below 102ºF per rectum or the equivalent, the child should be monitored, but does not need to be excluded for fever alone; g) Rash without fever and behavioral changes; h) Lice or nits (exclusion for treatment of an active lice infestation may be delayed until the end of the day); i) Ringworm (exclusion for treatment may be delayed until the end of the day); j) Molluscum contagiosum (do not require exclusion or covering of lesions); k) Thrush (i.e., white spots or patches in the mouth or on the cheeks or gums); l) Fifth disease (slapped cheek disease, parvovirus B19) once the rash has appeared; m) Methicillin-resistant Staphylococcus aureus, or MRSA, without an infection or illness that would otherwise require exclusion. Known MRSA carriers or colonized individuals should not be excluded; n) Cytomegalovirus infection; o) Chronic hepatitis B infection; p) Human immunodeficiency virus (HIV) infection; q) Asymptomatic children who have been previously evaluated and found to be shedding potentially infectious organisms in the stool. Children who are continent of stool or who are diapered with formed stools that can be contained in the diaper may return to care. For some infectious organisms, exclusion is required until certain guidelines have been met. Note: These					

agents are not common and caregivers/ teachers will usually not know the cause of most cases of diarrhea; r) Children with chronic infectious conditions that can be accommodated in the program according to the legal requirement of federal law in the Americans with Disabilities Act. The act requires that child care programs make reasonable accommodations for children with disabilities and/or chronic illnesses, considering each child individually. **Key criteria for exclusion of children who are ill:** When a child becomes ill but does not require immediate medical help, a determination must be made regarding whether the child should be sent home (i.e., should be temporarily "excluded" from child care). Most illnesses do not require exclusion. The caregiver/teacher should determine if the illness: a) Prevents the child from participating comfortably in activities; b) Results in a need for care that is greater than the staff can provide without compromising the health and safety of other children; c) Poses a risk of spread of harmful diseases to others. If any of the above criteria are met, the child should be excluded, regardless of the type of illness. The child should be removed from direct contact with other children and should be monitored and supervised by a single staff member known to the child until dismissed from care to the care of a parent/guardian or a primary care provider. The area should be where the toys, equipment, and surfaces will not be used by other children or adults until after the ill child leaves and after the surfaces and toys have been cleaned and disinfected. **Temporary exclusion is recommended when the child has any of the following conditions:** a) The illness prevents the child from participating comfortably in activities; b) The illness results in a need for care that is greater than the staff can provide without compromising the health and safety of other children; c) An acute change in behavior - this could include lethargy/lack of responsiveness, irritability,					

persistent crying, difficult breathing, or having a quickly spreading rash; d) Fever (temperature above 101°F [38.3°C] orally, above 102°F [38.9°C] rectally, or 100°F [37.8°C] or higher taken axillary [armpit] or measured by an equivalent method) and behavior change or other signs and symptoms (e.g., sore throat, rash, vomiting, diarrhea). An unexplained temperature above 100°F (37.8°C) axillary (armpit) or 101°F (38.3°C) rectally in a child younger than six months should be medically evaluated. Any infant younger than two months of age with any fever should get urgent medical attention. See COMMENTS Below for important information about taking temperatures; e) Diarrhea is defined by watery stools or decreased form of stool that is not associated with changes of diet. Exclusion is required for all diapered children whose stool is not contained in the diaper and toilet-trained children if the diarrhea is causing soiled pants or clothing. In addition, diapered children with diarrhea should be excluded if the stool frequency exceeds two or more stools above normal for that child, because this may cause too much work for the caregivers/teachers. Readmission after diarrhea can occur when diapered children have their stool contained by the diaper (even if the stools remain loose) and when toilet-trained children are continent. Special circumstances that require specific exclusion criteria include the following (2): 1) Toxin-producing *E. coli* or *Shigella* infection, until stools are formed and the test results of two stool cultures obtained from stools produced twenty-four hours apart do not detect these organisms; 2) *Salmonella* serotype Typhi infection, until diarrhea resolves. In children younger than five years with *Salmonella* serotype Typhi, three negative stool cultures obtained with twenty-four-hour intervals are required; people five years of age or older may return after a twenty-four-hour period without a diarrheal stool. Stool cultures should be collected from other attendees and staff members, and all infected people should be excluded; f) Blood or mucus in the stools not explained by					

dietary change, medication, or hard stools; g) Vomiting more than two times in the previous twenty-four hours, unless the vomiting is determined to be caused by a non-infectious condition and the child remains adequately hydrated; h) Abdominal pain that continues for more than two hours or intermittent pain associated with fever or other signs or symptoms of illness; i) Mouth sores with drooling unless the child's primary care provider or local health department authority states that the child is noninfectious; j) Rash with fever or behavioral changes, until the primary care provider has determined that the illness is not a infectious disease; k) Active tuberculosis, until the child's primary care provider or local health department states child is on appropriate treatment and can return; l) Impetigo, until treatment has been started; m) Streptococcal pharyngitis (i.e., strep throat or other streptococcal infection), until twenty-four hours after treatment has been started; n) Head lice until after the first treatment (note: exclusion is not necessary before the end of the program day); o) Scabies, until after treatment has been given; p) Chickenpox (varicella), until all lesions have dried or crusted (usually six days after onset of rash); q) Rubella, until six days after the rash appears; r) Pertussis, until five days of appropriate antibiotic treatment; s) Mumps, until five days after onset of parotid gland swelling; t) Measles, until four days after onset of rash; u) Hepatitis A virus infection, until one week after onset of illness or jaundice if the child's symptoms are mild or as directed by the health department. (Note: immunization status of child care contacts should be confirmed; within a fourteen-day period of exposure, incompletely immunized or unimmunized contacts from one through forty years of age should receive the hepatitis A vaccine as post exposure prophylaxis, unless contraindicated.) Other individuals may receive immune globulin. Consult with a primary care					

provider for dosage and recommendations; v) Any child determined by the local health department to be contributing to the transmission of illness during an outbreak.					
STANDARD 3.6.1.2: Staff Exclusion for Illness Please note that if a staff member has no contact with the children, or with anything with which the children come into contact, this standard may not apply to that staff member. A facility should not deny admission to or send home a staff member or substitute with illness unless one or more of the following conditions exists. The staff member should be excluded as follows: a) Chickenpox, until all lesions have dried and crusted, which usually occurs by six days; b) Shingles, only if the lesions cannot be covered by clothing or a dressing until the lesions have crusted; c) Rash with fever or joint pain, until diagnosed not to be measles or rubella; d) Measles, until four days after onset of the rash (if the staff member or substitute is immunocompetent); e) Rubella, until six days after onset of rash; f) Diarrheal illness, stool frequency exceeds two or more stools above normal for that individual or blood in stools, until diarrhea resolves; if *E. coli* 0157:H7 or *Shigella* is isolated, until diarrhea resolves and two stool cultures are negative, for *Salmonella* serotype Typhi, three stool cultures collected at twenty-four hour intervals and resolution of diarrhea is required; g) Vomiting illness, two or more episodes of vomiting during the previous twenty-four hours, until vomiting resolves or is determined to result from non-infectious conditions; h) Hepatitis A virus, until one week after symptom onset or as directed by the health department; i) Pertussis, until after five days of appropriate antibiotic therapy; j) Skin infection (such as impetigo), until treatment has been initiated; exclusion should continue if lesion is draining AND cannot be covered;		Not addressed.		DECAL may want to address this specific standard and add it to their rules.	

k) Tuberculosis, until noninfectious and cleared by a health department official or a primary care provider; l) Strep throat or other streptococcal infection, until twenty-four hours after initial antibiotic treatment and end of fever; m) Head lice, from the end of the day of discovery until after the first treatment; n) Scabies, until after treatment has been completed; o) Haemophilus influenzae type b (Hib), prophylaxis, until antibiotic treatment has been initiated; p) Meningococcal infection, until appropriate therapy has been administered for twenty-four hours; q) Respiratory illness, if the illness limits the staff member's ability to provide an acceptable level of child care and compromises the health and safety of the children. Caregivers/teachers who have herpes cold sores should not be excluded from the child care facility, but should: a) Cover and not touch their lesions; b) Carefully observe hand hygiene policies.					
STANDARD 3.6.1.4: Infectious Disease Outbreak Control During the course of an identified outbreak of any report-able illness at the facility, a child or staff member should be excluded if the health department official or primary care provider suspects that the child or staff member is con-tributing to transmission of the illness at the facility, is not adequately immunized when there is an outbreak of a vac-cine preventable disease, or the circulating pathogen poses an increased risk to the individual. The child or staff member should be readmitted when the health department official or primary care provider who made the initial determination decides that the risk of transmission is no longer present.	**290-2-3-.14 Reporting** (3) Any cases or suspected cases of notifiable communicable diseases shall be reported to the local county health department in accordance with rules of the department regarding Notification of Disease, Chapter 290-5-3, and to the Child Care Licensing Office.	Partially meets.	The rule addresses reporting the case but says nothing about excluding the staff or child who may be contributing to the outbreak.	DECAL may want to include the wording from the Stepping Stones standard.	
STANDARD 3.6.2.10: Inclusion and Exclusion of Children from Facilities That Serve Children Who Are		Not addressed.		DECAL may want to address this specific standard and add it to their rules.	

Ill Facilities that care for children who are ill who have conditions that require additional attention from the caregiver/ teacher, should arrange for or ask the child care health consultant to arrange for a clinical health evaluation, by a licensed primary care provider, for each child who is admitted to the facility. These facilities should include children with conditions listed in Standard 3.6.1.1 if their policies and plans address the management of these conditions, except for the following conditions which require exclusion from all types of child care facilities that are not medical care institutions (such as hospitals or skilled nursing facilities): a) Fever (see COMMENTS section for definition of fever) and a stiff neck, lethargy, irritability, or persistent crying; b) Diarrhea (loose stools, not contained in the diaper, that are two or more greater than normal frequency) and one or more of the following: 1) Signs of dehydration, such as dry mouth, no tears, lethargy, sunken fontanelle (soft spot on the head); 2) Blood or mucus in the stool until it is evaluated for organisms tha can cause dysentery; 3) Diarrhea caused by *Salmonella*, *Campylobacter*, *Giardia*, *Shigella* or *E.coli* 0157:H7 until specific criteria for treatment and return to care are met. c) Vomiting with signs of dehydration and inability to maintain hydration with oral intake; d) Contagious stages of pertussis, measles, mumps, chickenpox, rubella, or diphtheria, unless the child is appropriately isolated from children with other illnesses and cared for only with children having the same illness; e) Untreated infestation of scabies or head lice; f) Untreated infectious tuberculosis; g) Undiagnosed rash WITH fever or behavior change; h) Abdominal pain that is intermittent or persistent and is accompanied by fever, diarrhea, or vomiting; i) Difficulty in breathing; j) An acute change in behavior; k) Undiagnosed jaundice (yellow skin and whites of eyes);					

l) Other conditions as may be determined by the director or child care health consultant; m) Upper or lower respiratory infection in which signs or symptoms require a higher level of care than can be appropriately provided.					
STANDARD 3.6.2.2: Space Requirements for Care of Children Who Are Ill Environmental space utilized for the care of children who are ill with infectious diseases and cannot receive care in their usual child care group should meet all requirements for well children and include the following additional requirements: a) If the program for children who are ill is in the same facility as the well-child program, well children should not use or share furniture, fixtures, equipment, or supplies designated for use with children who are ill unless it has been cleaned and sanitized before use by well children; b) Indoor space that the facility uses for children who are ill, including hallways, bathrooms, and kitchens, should be separate from indoor space used with well children; this reduces the likelihood of mixing supplies, toys, and equipment. The facility may use a single kitchen for ill and well children if the kitchen is staffed by a cook who has no child care responsibilities other than food preparation and who does not handle soiled dishes and utensils until after food preparation and food service are completed for any meal; c) Children whose symptoms indicate infections of the gastrointestinal tract (often with diarrhea) who receive care in special facilities for children who are ill should receive this care in a space separate from other children with other illnesses to reduce the likelihood of disease being transmitted between children by limiting child-to-child interaction, separating staff responsibilities, and not mixing supplies, toys, and equipment; d) If the facility cares for children with chickenpox, these children require a room with separate ventilation with exhaust to, and air exchange with, the outside (3); e) Each child care room should have a handwashing sink that can provide a steady stream		Not addressed.		DECAL may want to address this specific standard and add it to their rules.	

of water, between 60°F and 120°F, at least for ten seconds. Soap and disposable paper towels should be available at the handwashing sink at all times. A hand sanitizing dispenser is an alternative to traditional handwashing; f) Each room where children who wear diapers receive care should have its own diaper changing area adjacent to a handwashing sink and/or hand sanitizer dispenser.					
STANDARD 3.6.2.5: Caregiver/Teacher Qualifications for Facilities That Care for Children Who Are Ill Each caregiver/teacher in a facility that cares for children who are ill should have at least two years of successful work experience as a caregiver/teacher in a regular well-child facility prior to employment in the special facility. In addition, facilities should document, for each caregiver/teacher, twenty hours of pre-service orientation training on care of children who are ill beyond the orientation training specified in Standards 1.4.2.1 through Standard 1.4.2.3. This training should include the following subjects: a) Pediatric first aid and CPR, and first aid for choking; b) General infection-control procedures, including: 1) Hand hygiene; 2) Handling of contaminated items; 3) Use of sanitizing chemicals; 4) Food handling; 5) Washing and sanitizing of toys; 6) Education about methods of disease transmission. c) Care of children with common mild childhood illnesses, including: 1) Recognition and documentation of signs and symptoms of illness including body temperature; 2) Administration and recording of medications; 3) Nutrition of children who are ill; 4) Communication with parents/guardians of children who are ill; 5) Knowledge of immunization requirements; 6) Recognition of need for medical assistance and how to access;		Not addressed.		DECAL may want to address this specific standard and add it to their rules.	

7) Knowledge of reporting requirements for infectious diseases; 8) Emergency procedures. d) Child development activities for children who are ill; e) Orientation to the facility and its policies. This training should be documented in the staff personnel files, and compliance with the content of training routinely evaluated. Based on these evaluations, the training on care of children who are ill should be updated with a minimum of six hours of annual training for individuals who continue to provide care to children who are ill.					
STANDARD 3.6.3.1: Medication Administration The administration of medicines at the facility should be limited to: a) Prescription or non-prescription medication (over-the-counter [OTC]) ordered by the prescribing health professional for a specific child with written permission of the parent/guardian. Written orders from the prescribing health professional should specify medical need, medication, dosage, and length of time to give medication; b) Labeled medications brought to the child care facility by the parent/guardian in the original container (with a label that includes the child's name, date filled, prescribing clinician's name, pharmacy name and phone number, dosage/instructions, and relevant warnings). Facilities should not administer folk or homemade remedy medications or treatment. Facilities should not administer a medication that is prescribed for one child in the family to another child in the family. No prescription or non-prescription medication (OTC) should be given to any child without written orders from a prescribing health professional and written permission from a parent/guardian. Exception: Non-prescription sunscreen and insect repellent always require parental consent but do not require instructions from each child's prescribing health professional. Documentation that the medicine/agent is administered to the child as prescribed is required.	**290-2-3-.11 Health, Safety, and Discipline** Except for first aid, personnel shall not dispense prescription or nonprescription medications to a child without specific written authorization from the child's physician, parent or guardian. All medications shall be stored in accordance with the prescription or label instructions and kept in places that are inaccessible to children. Each dose of medication given to a child shall be documented showing the child's name, name of medication, date and time given, and the name of the person giving the medication.	Meets.			

"Standing orders" guidance should include directions for facilities to be equipped, staffed, and monitored by the primary care provider capable of having the special health care plan modified as needed. Standing orders for medication should only be allowed for individual children with a documented medical need if a special care plan is provided by the child's primary care provider in conjunction with the standing order or for OTC medications for which a primary care provider has provided specific instructions that define the children, conditions and methods for administration of the medication. Signatures from the primary care provider and one of the child's parents/guardians must be obtained on the special care plan. Care plans should be updated as needed, but at least yearly.					
STANDARD 3.6.3.2: Labeling, Storage, and Disposal of Medications Any prescription medication should be dated and kept in the original container. The container should be labeled by a pharmacist with: • The child's first and last names; • The date the prescription was filled; • The name of the prescribing health professional who wrote the prescription, the medication's expiration date; • The manufacturer's instructions or prescription label with specific, legible instructions for administration, storage, and disposal; • The name and strength of the medication. Over-the-counter medications should be kept in the original container as sold by the manufacturer, labeled by the parent/guardian, with the child's name and specific instructions given by the child's prescribing health professional for administration. All medications, refrigerated or unrefrigerated, should: • Have child-resistant caps; • Be kept in an organized fashion; • Be stored away from food; • Be stored at the proper temperature; • Be completely inaccessible to children. Medication should not be used beyond the date of expiration. Unused medications should be returned to the parent/	**290-2-3-.11 Health, Safety, and Discipline** (e) Except for first aid, personnel shall not dispense prescription or nonprescription medications to a child without specific written authorization from the child's physician, parent or guardian. All medications shall be stored in accordance with the prescription or label instructions and kept in places that are inaccessible to children. Each dose of medication given to a child shall be documented showing the child's name, name of medication, date and time given, and the name of the person giving the medication.	Partially meets.	This rule has all the major areas from the Stepping Stones standard with the exception of what to do with medications if they cannot be returned to the parents.	DECAL should adopt the language in the Stepping Stones standard on what to do if medications cannot be returned to the parents. There are guidelines for doing this as stated in the standard.	

guardian for disposal. In the event medication cannot be returned to the parent or guardian, it should be disposed of according to the recommendations of the US Food and Drug Administration (FDA) (1). Documentation should be kept with the child care facility of all disposed medications. The current guidelines are as follows: a) If a medication lists any specific instructions on how to dispose of it, follow those directions. b) If there are community drug take back programs, participate in those. c) Remove medications from their original containers and put them in a sealable bag. Mix medications with an undesirable substance such as used coffee grounds or kitty litter. Throw the mixture into the regular trash. Make sure children do not have access to the trash.					
STANDARD 3.6.3.3: Training of Caregivers/ Teachers to Administer Medication Any caregiver/teacher who administers medication should complete a standardized training course that includes skill and competency assessment in medication administration. The trainer in medication administration should be a licensed health professional. The course should be repeated according to state and/or local regulation. At a minimum, skill and competency should be monitored annually or whenever medication administration error occurs. In facilities with large numbers of children with special health care needs involving daily medication, best practice would indicate strong consideration to the hiring of a licensed health care professional. Lacking that, caregivers/teachers should be trained to: a) Check that the name of the child on the medication and the child receiving the medication are the same; b) Check that the name of the medication is the same as the name of the medication on the instructions to give the medication if the instructions are not on the medication container that is labeled with the child's name; c) Read and understand the label/prescription directions or the separate written instructions in relation to the measured dose, frequency, route of administration (ex. by mouth, ear canal, eye, etc.) and other special instructions relative to the		Not addressed.		DECAL may want to address this specific standard and add it to their rules.	

medication; d) Observe and report any side effects from medications; e) Document the administration of each dose by the time and the amount given; f) Document the person giving the administration and any side effects noted; g) Handle and store all medications according to label instructions and regulations. The trainer in medication administration should be a licensed health professional: Registered Nurse, Advanced Practice Registered Nurse (APRN), MD, Physician's Assistant, or Pharmacist.					
STANDARD 4.2.0.10: Care for Children with Food Allergies When children with food allergies attend the early care and education facility, the following should occur: a) Each child with a food allergy should have a care plan prepared for the facility by the child's primary care provider, to include: 1) Written instructions regarding the food(s) to which the child is allergic and steps that need to be taken to avoid that food; 2) A detailed treatment plan to be implemented in the event of an allergic reaction, including the names, doses, and methods of administration of any medications that the child should receive in the event of a reaction. The plan should include specific symptoms that would indicate the need to administer one or more medications; b) Based on the child's care plan, the child's caregivers/ teachers should receive training, demonstrate competence in, and implement measures for: 1) Preventing exposure to the specific food(s) to which the child is allergic; 2) Recognizing the symptoms of an allergic reaction; 3) Treating allergic reactions; c) Parents/guardians and staff should arrange for the facility to have necessary medications, proper storage of such medications, and the equipment		Not addressed.		DECAL may want to address this specific standard and add it to their rules.	

and training to manage the child's food allergy while the child is at the early care and education facility; d) Caregivers/teachers should promptly and properly administer prescribed medications in the event of an allergic reaction according to the instructions in the care plan; e) The facility should notify the parents/guardians immediately of any suspected allergic reactions, the ingestion of the problem food, or contact with the problem food, even if a reaction did not occur; f) The facility should recommend to the family that the child's primary care provider be notified if the child has required treatment by the facility for a food allergic reaction; g) The facility should contact the emergency medical services system immediately whenever epinephrine has been administered; h) Parents/guardians of all children in the child's class should be advised to avoid any known allergens in class treats or special foods brought into the early care and education setting; i) Individual child's food allergies should be posted prominently in the classroom where staff can view and/or wherever food is served; j) The written child care plan, a mobile phone, and the proper medications for appropriate treatment if the child develops an acute allergic reaction should be routinely carried on field trips or transport out of the early care and education setting.					
STANDARD 4.2.0.6: Availability of Drinking Water Clean, sanitary drinking water should be readily available, in indoor and outdoor areas, throughout the day. Water should not be a substitute for milk at meals or snacks where milk is a required food component unless it is recommended by the child's primary care provider. On hot days, infants receiving human milk in a bottle can be given additional human milk in a bottle but should not be given water, especially in the first six months of life. Infants receiving formula and water can be given additional formula in a bottle. Toddlers and older children will need additional water as physical activity and/or hot temperatures cause their needs to increase. Children should		Not addressed.		DECAL may want to address this specific standard and add it to their rules.	

learn to drink water from a cup or drinking fountain without mouthing the fixture. They should not be allowed to have water continuously in hand in a "sippy cup" or bottle. Permitting toddlers to suck continuously on a bottle or sippy cup filled with water, in order to soothe themselves, may cause nutritional or in rare instances, electrolyte imbalances. When tooth brushing is not done after a feeding, children should be offered water to drink to rinse food from their teeth.					
STANDARD 4.2.0.8: Feeding Plans and Dietary Modifications Before a child enters an early care and education facility, the facility should obtain a written history that contains any special nutrition or feeding needs for the child, including use of human milk or any special feeding utensils. The staff should review this history with the child's parents/guardians, clarifying and discussing how parental/guardian home feeding routines may differ from the facility's planned routine. The child's primary care provider should provide written information about any dietary modifications or special feeding techniques that are required at the early care and education program and these plans should be shared with the child's parents/guardians upon request. If dietary modifications are indicated, based on a child's medical or special dietary needs, the caregiver/teacher should modify or supplement the child's diet to meet the individual child's specific needs. Dietary modifications should be made in consultation with the parents/guardians and the child's primary care provider. Caregivers/teachers can consult with a nutritionist/registered dietitian. Reasons for modification of a child's diet may be related to food sensitivity. Food sensitivity includes a range of conditions in which a child exhibits an adverse reaction to a food that, in some instances, can be life threatening. Modification of a child's diet may be related to a food allergy, inability to digest or to tolerate certain foods, need for extra calories, need for special positioning while eating, diabetes and the need to match food with insulin, food idiosyncrasies, and other identified feeding issues. Examples include celiac disease, phenylketonuria, diabetes, severe food allergy (anaphylaxis), and others. In some	**290-2-3-.10 Nutrition and Food Services.** (4) The provider shall secure from the parents infant formula and a feeding plan for children under 1 year of age.	Partially meets.	The rule addresses the need for a written feeding plan but the rule does not deal with the specific written instructions for a child identified with special health care needs other than that a written statement from a medical authority shall be on file.	DECAL should adopt the specific language from the standard regarding the written instructions for a child identified with special health care needs.	

cases, a child may become ill if the child is unable to eat, so missing a meal could have a negative consequence, especially for diabetics. For a child identified with special health care needs for dietary modification or special feeding techniques, written instructions from the child's parent/guardian and the child's primary care provider should be provided in the child's record and carried out accordingly. Dietary modifications should be recorded. These written instructions must identify: a) The child's full name and date of instructions; b) The child's special needs; c) Any dietary restrictions based on the special needs; d) Any special feeding or eating utensils; e) Any foods to be omitted from the diet and any foods to be substituted; f) Limitations of life activities; g) Any other pertinent special needs information; h) What, if anything, needs to be done if the child is exposed to restricted foods. The written history of special nutrition or feeding needs should be used to develop individual feeding plans and, collectively, to develop facility menus. Disciplines related to special nutrition needs, including nutrition, nursing, speech, occupational therapy, and physical therapy, should participate when needed and/or when they are available to the facility. The nutritionist/registered dietitian should approve menus that accommodate needed dietary modifications. The feeding plan should include steps to take when a situation arises that requires rapid response by the staff, such as a child's choking during mealtime or a child with a known history of food allergies demonstrating signs and symptoms of anaphylaxis (severe allergic reaction, e.g., difficulty breathing or severe redness and swelling of the face or mouth). The completed plan should be on file and accessible to the staff and available to parents/guardians upon request.					
STANDARD 4.3.1.11: Introduction of Age-Appropriate Solid Foods to Infants		Not addressed.		DECAL may want to address this specific standard and add it to their rules.	

A plan to introduce age-appropriate solid foods (complementary foods) to infants should be made in consultation with the child's parent/guardian and primary care provider. Age-appropriate solid foods may be introduced no sooner than when the child has reached the age of four months, but preferably six months and as indicated by the individual child's nutritional and developmental needs. For breastfed infants, gradual introduction of iron-fortified foods may occur no sooner than around four months, but preferably six months and to complement the human milk. Modification of basic food patterns should be provided in writing by the child's primary care provider. Evidence for introducing complementary foods in a specific order or rate is not available. The current best practice is that the first solid foods should be single-ingredient foods and should be introduced one at a time at two- to seven-day intervals (1).					
STANDARD 4.3.1.3: Preparing, Feeding, and Storing Human Milk Expressed human milk should be placed in a clean and sanitary bottle with a nipple that fits tightly or into an equivalent clean and sanitary sealed container to prevent spilling during transport to home or to the facility. Only cleaned and sanitized bottles, or their equivalent, and nipples should be used in feeding. The bottle or container should be properly labeled with the infant's full name and the date and time the milk was expressed. The bottle or container should immediately be stored in the refrigerator on arrival. The mother's own expressed milk should only be used for her own infant. Likewise, infant formula should not be used for a breastfed infant without the mother's written permission. Bottles made of plastics containing BPA or phthalates should be avoided (labeled with #3, #6, or #7). Glass bottles or plastic bottles labeled BPA-free or with #1, #2, #4, or #5 are acceptable. Non-frozen human milk should be transported and stored in the containers to be used to feed the infant, identified with a label which will not come off in water or handling, bearing the date of collection and child's full name. The		Not addressed.		DECAL may want to address this specific standard and add it to their rules.	

filled, labeled containers of human milk should be kept refrigerated. Human milk containers with significant amount of contents remaining (greater than one ounce) may be returned to the mother at the end of the day as long as the child has not fed directly from the bottle. Frozen human milk may be transported and stored in single use plastic bags and placed in a freezer (not a compartment within a refrigerator but either a freezer with a separate door or a standalone freezer). Human milk should be defrosted in the refrigerator if frozen, and then heated briefly in bottle warmers or under warm running water so that the temperature does not exceed 98.6°F. If there is insufficient time to defrost the milk in the refrigerator before warming it, then it may be defrosted in a container of running cool tap water, very gently swirling the bottle periodically to evenly distribute the temperature in the milk. Some infants will not take their mother's milk unless it is warmed to body temperature, around 98.6°F. The caregiver/teacher should check for the infant's full name and the date on the bottle so that the oldest milk is used first. After warming, bottles should be mixed gently (not shaken) and the temperature of the milk tested before feeding. Expressed human milk that presents a threat to an infant, such as human milk that is in an unsanitary bottle, is curdled, smells rotten, and/or has not been stored following the storage guidelines of the Academy of Breastfeeding Medicine as shown later in this standard, should be returned to the mother. Some children around six months to a year of age may be developmentally ready to feed themselves and may want to drink from a cup. The transition from bottle to cup can come at a time when a child's fine motor skills allow use of a cup. The caregiver/teacher should use a clean small cup without cracks or chips and should help the child to lift and tilt the cup to avoid spillage and leftover fluid. The caregiver/ teacher and mother should work together on cup feeding of human milk to ensure the child is receiving adequate nourishment and to avoid having a large amount of human milk remaining at the end of feeding. Two to three ounces of human milk can be placed in a clean cup and additional milk can be offered as needed. Small amounts of human milk (about an ounce) can be discarded. Human milk can be stored using the following guidelines					

from the Academy of Breastfeeding Medicine: **Guidelines for Storage of Human Milk** **Location** / **Temperature** / **Duration** / **Comments** Countertop, table — Room temperature (up to 77°F or 25°C) — 6-8 hours — Containers should be covered and kept as cool as possible; covering the container with a cool towel may keep milk cooler. Insulated cooler bag — 5°F – 39°F or -15°C – 4°C — 24 hours — Keep ice packs in contact with milk containers at all times, limit opening cooler bag. Refrigerator — 39°F or 4°C — 5 days — Store milk in the back of the main body of the refrigerator. Freezer compartment of a refrigerator — 5°F or -15°C — 2 weeks — Store milk toward the back of the freezer, where temperature is most constant. Milk stored for longer durations in the ranges listed is safe, but some of the lipids in the milk undergo degradation resulting in lower quality. Freezer compartment of refrigerator with separate doors — 0°F or -18°C — 3-6 months Chest or upright deep freezer — -4°F or -20°C — 6-12 months					
STANDARD 4.3.1.5: Preparing, Feeding, and Storing Infant Formula Formula provided by parents/guardians or by the facility should come in a factory-sealed container. The formula should be of the same brand that is served at home and should be of ready-to-feed strength or liquid concentrate to be diluted using water from a source approved by the health department. Powdered infant formula, though it is the least expensive formula, requires special handling in mixing because it cannot be sterilized. The primary source for proper and safe handling and mixing is the manufacturer's instructions that appear on the can of powdered formula. Before opening the can, hands should be washed. The can and plastic lid should be thoroughly rinsed and dried. Caregivers/teachers should read and follow the manufacturer's directions. If instructions are not readily available, caregivers/ teachers should obtain information from the World Health Organization's *Safe Preparation, Storage and Handling of Powdered Infant Formula Guidelines* at http://www.who.int/	**290-2-3-.10 Nutrition and Food Services.** (5) Infant formula bottles shall be labeled with the individual child's name. Any unused formula or milk shall be discarded or returned to the parent at the end of the day.	Does not meet.	Rule only addresses that infant formula bottles should be labeled and what to do with unused formula or milk.	DECAL should add language from the Stepping Stones standard regarding the details for preparing, feeding, and storing infant formula.	

foodsafety/publications/micro/pif2007/en/index.html (8). The local WIC program can also provide instructions. Formula mixed with cereal, fruit juice, or any other foods should not be served unless the child's primary care provider provides written documentation that the child has a medical reason for this type of feeding. Iron-fortified formula should be refrigerated until immediately before feeding. For bottles containing formula, any contents remaining after a feeding should be discarded. Bottles of formula prepared from powder or concentrate or ready-to-feed formula should be labeled with the child's full name and time and date of preparation. Any prepared formula must be discarded within one hour after serving to an infant. Prepared powdered formula that has not been given to an infant should be covered, labeled with date and time of preparation and child's full name, and may be stored in the refrigerator for up to twenty-four hours. An open container of ready-to-feed, concentrated formula, or formula prepared from concentrated formula, should be covered, refrigerated, labeled with date of opening and child's full name, and discarded at forty-eight hours if not used (7,9). The caregiver/teacher should always follow manufacturer's instructions for mixing and storing of any formula preparation. Some infants will require specialized formula because of allergy, inability to digest certain formulas, or need for extra calories. The appropriate formula should always be available and should be fed as directed. For those infants getting supplemental calories, the formula may be prepared in a different way from the directions on the container. In those circumstances, either the family should provide the prepared formula or the caregiver/teacher should receive special training, as noted in the infant's care plan, on how to prepare the formula.					
STANDARD 4.5.0.10: Foods that Are Choking Hazards Caregivers/teachers should not offer to children under four years of age foods that are associated with young children's choking incidents (round, hard, small, thick and sticky, smooth, compressible or dense, or slippery). Examples of these foods are hot dogs and other meat sticks (whole or sliced into rounds), raw carrot rounds, whole grapes, hard candy, nuts, seeds, raw peas, hard pretzels, chips, peanuts,		Not addressed.		DECAL may want to address this specific standard and add it to their rules.	

popcorn, rice cakes, marshmallows, spoonfuls of peanut butter, and chunks of meat larger than can be swallowed whole. Food for infants should be cut into pieces one-quarter inch or smaller, food for toddlers should be cut into pieces one-half inch or smaller to prevent choking. In addition to the food monitoring, children should always be seated when eating to reduce choking hazards. Children should be supervised while eating, to monitor the size of food and that they are eating appropriately (for example, not stuffing their mouths full).					
STANDARD 4.5.0.6: Adult Supervision of Children Who Are Learning to Feed Themselves Children in mid-infancy who are learning to feed themselves should be supervised by an adult seated within arm's reach of them at all times while they are being fed. Children over twelve months of age who can feed themselves should be supervised by an adult who is seated at the same table or within arm's reach of the child's highchair or feeding table. When eating, children should be within sight of an adult at all times.		Not addressed.		DECAL may want to address this specific standard and add it to their rules.	
STANDARD 4.5.0.9: Hot Liquids and Foods Adults should not consume hot liquids above 120°F in child care areas. Hot liquids and hot foods should be kept out of the reach of infants, toddlers, and preschoolers. Hot liquids and foods should not be placed on a surface at a child›s level, at the edge of a table or counter, or on a table-cloth that could be yanked down. Appliances containing hot liquids, such as coffee pots and crock pots, should be kept out of the reach of children. Electrical cords from any appliance, including coffee pots, should not be allowed to hang within the reach of children. Food preparers should position pot handles toward the back of the stove and use only back burners when possible.		Not addressed.		DECAL may want to address this specific standard and add it to their rules.	
STANDARD 4.8.0.1: Food Preparation Area The food preparation area of the kitchen should be separate from eating, play, laundry, toilet, and bathroom areas and from areas where animals are permitted. The food prepara-tion area should not be used as a passageway while food is being prepared. Food preparation areas should be separated by a door, gate, counter, or room divider from areas the		Not addressed.		DECAL may want to address this specific standard and add it to their rules.	

children use for activities unrelated to food, except in small family child care homes when separation may limit supervision of children. Infants and toddlers should not have access to the kitchen in child care centers. Access by older children to the kitchen of centers should be permitted only when supervised by staff members who have been certified by the nutritionist/ registered dietitian or the center director as qualified to follow the facility's sanitation and safety procedures. In all types of child care facilities, children should never be in the kitchen unless they are directly supervised by a caregiver/teacher. Children of preschool-age and older should be restricted from access to areas where hot food is being prepared. School-age children may engage in food preparation activities with adult supervision in the kitchen or the classroom. Parents/guardians and other adults should be permitted to use the kitchen only if they know and follow the food safety rules of the facility. The facility should check with local health authorities about any additional regulations that apply.					
STANDARD 4.8.0.3: Maintenance of Food Service Surfaces and Equipment All surfaces that come into contact with food, including tables and countertops, as well as floors and shelving in the food preparation area should be in good repair, free of cracks or crevices, and should be made of smooth, non-porous material that is kept clean and sanitized. All kitchen equipment should be clean and should be maintained in operable condition according to the manufacturer's guidelines for maintenance and operation. The facility should maintain an inventory of food service equipment that includes the date of purchase, the warranty date, and a history of repairs.	**290-2-3-.10 Nutrition and Food Services** (12) Food preparation surface areas shall be nonporous with no cracks or unsealed seams. (13) Food preparation areas and equipment shall be kept clean and free of accumulation of dust, dirt, food particles, and grease deposits.	Meets.			
STANDARD 4.9.0.2: Staff Restricted from Food Preparation and Handling Anyone who has signs or symptoms of illness, including vomiting, diarrhea, and infectious skin sores that cannot be covered, or who potentially or actually is infected with bac-	**290-2-3-.10 Nutrition and Food Services** (14) The person preparing meals shall wash their hands and arms thoroughly with soap and warm water before starting food service work and as often as necessary during food preparation and serving to	Partially meets.	Rule only addresses washing of hands.	DECAL needs to add the additional language of the Stepping Stones standard regarding staff restrictions.	

teria, viruses or parasites that can be carried in food, should be excluded from food preparation and handling. Staff members may not contact exposed, ready-to-eat food with their bare hands and should use suitable utensils such as deli tissue, spatulas, tongs, single-use gloves, or dispensing equipment. No one with open or infected skin eruptions should work in the food preparation area unless the injuries are covered with nonporous (such as latex or vinyl), single use gloves. In centers and large family child care homes, staff members who are involved in the process of preparing or handling food should not change diapers. Staff members who work with diapered children should not prepare or serve food for older groups of children. When staff members who are caring for infants and toddlers are responsible for changing diapers, they should handle food only for the infants and toddlers in their groups and only after thoroughly washing their hands. Caregivers/teachers who prepare food should wash their hands carefully before handling any food, regardless of whether they change diapers. When caregivers/teachers must handle food, staffing assignments should be made to foster completion of the food handling activities by caregivers/teachers of older children, or by caregivers/teachers of infants and toddlers before the caregiver/teacher assumes other caregiving duties for that day. Aprons worn in the food service area must be clean and should be removed when diaper changing or when using the toilet.	remove soil and contamination.				
STANDARD 4.9.0.3: Precautions for a Safe Food Supply All foods stored, prepared, or served should be safe for human consumption by observation and smell. The following precautions should be observed for a safe food supply: a) Home-canned food; food from dented, rusted, bulging, or leaking cans, and food from cans without labels should not be used; b) Foods should be inspected daily for spoilage or signs of mold, and foods that are spoiled or moldy should be promptly and appropriately discarded; c) Meat should be from government-inspected sources or otherwise approved by the governing health authority (3);	**290-2-3-.10 Nutrition and Food Services** (7) Food shall be in sound condition, free from spoilage and contamination, and shall be safe for human consumption.	Partially meets.	Rule does not contain the specific detailed language as in the Stepping Stones standard but does exceed the Stepping Stones standard.	DECAL should consider adding the additional specific and detailed language contained in the Stepping Stones standard.	

d) All dairy products should be pasteurized and Grade A where applicable; e) Raw, unpasteurized milk, milk products; unpasteurized fruit juices; and raw or undercooked eggs should not be used. Freshly squeezed fruit or vegetable juice prepared just prior to serving in the child care facility is permissible; f) Unless a child's health care professional documents a different milk product, children from twelve months to two years of age should be served only human milk, formula, whole milk or 2% milk (6). Note: For children between twelve months and two years of age for whom overweight or obesity is a concern or who have a family history of obesity, dyslipidemia, or CVD, the use of reduced-fat milk is appropriate only with written documentation from the child's primary health care professional (4). Children two years of age and older should be served skim or 1% milk. If cost-saving is required to accommodate a tight budget, dry milk and milk products may be reconstituted in the facility for cooking purposes only, provided that they are prepared, refrigerated, and stored in a sanitary manner, labeled with the date of preparation, and used or discarded within twenty-four hours of preparation; g) Meat, fish, poultry, milk, and egg products should be refrigerated or frozen until immediately before use (5); h) Frozen foods should be defrosted in one of four ways: In the refrigerator; under cold running water; as part of the cooking process, or by removing food from packaging and using the defrost setting of a microwave oven (5). Note: Frozen human milk should not be defrosted in the microwave; i) Frozen foods should never be defrosted by leaving them at room temperature or standing in water that is not kept at refrigerator temperature (5); j) All fruits and vegetables should be washed thoroughly with water prior to use (5); k) Food should be served promptly after preparation or cooking or should be maintained at temperatures of not less than 135°F for hot foods and not more than 41°F for cold foods (12);					

l) All opened moist foods that have not been served should be covered, dated, and maintained at a temperature of 41°F or lower in the refrigerator or frozen in the freezer, verified by a working thermometer kept in the refrigerator or freezer (12); m) Fully cooked and ready-to-serve hot foods should be held for no longer than thirty minutes before being served, or promptly covered and refrigerated; n) Pasteurized eggs or egg products should be substituted for raw eggs in the preparation of foods such as Caesar salad, mayonnaise, meringue, eggnog, and ice cream. Pasteurized eggs or egg products should be substituted for recipes in which more than one egg is broken and the eggs are combined, unless the eggs are cooked for an individual child at a single meal and served immediately, such as in omelets or scrambled eggs; or the raw eggs are combined as an ingredient immediately before baking and the eggs are fully cooked to a ready-to-eat form, such as a cake, muffin or bread; o) Raw animal foods should be fully cooked to heat all parts of the food to a temperature and for a time of; 145°F or above for fifteen seconds for fish and meat; 160°F for fifteen seconds for chopped or ground fish, chopped or ground meat or raw eggs; or 165°F or above for fifteen seconds for poultry or stuffed fish, stuffed meat, stuffed pasta, stuffed poultry or stuffing containing fish, meat or poultry.					
STANDARD 5.1.1.2: Inspection of Buildings Newly constructed, renovated, remodeled, or altered buildings should be inspected by a public inspector to assure compliance with applicable building and fire codes before the building can be made accessible to children.		Not addressed.		DECAL may want to address this specific standard and add it to their rules.	
STANDARD 5.1.1.3: Compliance with Fire Prevention Code Every twelve months, the child care facility should obtain written documentation to submit to the regulatory licensing authority that the facility complies with a state-approved or nationally recognized Fire Prevention Code. If available,		Not addressed.		DECAL may want to address this specific standard and add it to their rules.	

this documentation should be obtained from a fire prevention official with jurisdiction where the facility is located. Where fire safety inspections or a Fire Prevention Code applicable to child care centers is not available from local authorities, the facility should arrange for a fire safety inspection by an inspector who is qualified to conduct such inspections using the National Fire Protection Association's *NFPA 101: Life Safety Code*.					
STANDARD 5.1.1.5: Environmental Audit of Site Location An environmental audit should be conducted before construction of a new building; renovation or occupation of an older building; or after a natural disaster, to properly evaluate and, where necessary, remediate or avoid sites where children's health could be compromised (1,3). The environmental audit should include assessments of: a) Potential air, soil, and water contamination on child care facility sites and outdoor play spaces; b) Potential toxic or hazardous materials in building construction; and c) Potential safety hazards in the community surrounding the site. A written environmental audit report that includes any remedial action taken should be kept on file.		Not addressed.		DECAL may want to address this specific standard and add it to their rules.	
STANDARD 5.1.6.6: Guardrails and Protective Barriers Guardrails, a minimum of thirty-six inches in height, should be provided at open sides of stairs, ramps, and other walking surfaces (e.g., landings, balconies, porches) from which there is more than a thirty-inch vertical distance to fall. Spaces below the thirty-six inches height guardrail should be further divided with intermediate rails or balusters as detailed in the next paragraph. For preschoolers, bottom guardrails greater than nine inches but less or equal to twenty-three inches above the floor should be provided for all porches, landings, balconies, and similar structures. For school age children, bottom guardrails should be greater than nine inches but less or equal to twenty inches above the floor, as specified above.		Not addressed.		DECAL may want to address this specific standard and add it to their rules.	

For infants and toddlers, protective barriers should be less than three and one-half inches above the floor, as specified above. All spaces in guardrails should be less than three and a half inches. All spaces in protective barriers should be less than three and one-half inches. If spaces do not meet the specifications as listed above, a protective material sufficient to prevent the passing of a three and one-half inch diameter sphere should be provided. Where practical or otherwise required by applicable codes, guardrails should be a minimum of forty-two inches in height to help prevent falls over the open side by staff and other adults in the child care facility.					
STANDARD 5.2.1.10: Gas, Oil, or Kerosene Heaters, Generators, Portable Gas Stoves, and Charcoal and Gas Grills Unvented gas or oil heaters and portable open-flame kerosene space heaters should be prohibited. Gas cooking appliances, including portable gas stoves, should not be used for heating purposes. Charcoal grills should not be used for space heating or any other indoor purposes. Heat in units that involve flame should be vented properly to the outside and should be supplied with a source of combustion air that meets the manufacturer's installation requirements.	**290-2-3-.13 Building and Grounds.** (e) When in use, radiators, open fire, oil or wood burning stoves, floor furnaces and similar hazards shall have barriers or screens to prevent children from being burned. (f) Unvented fuel fired heaters shall not be used unless equipped with an oxygen depletion safety shut off system.	Meets.			
STANDARD 5.2.4.2: Safety Covers and Shock Protection Devices for Electrical Outlets All electrical outlets accessible to children who are not yet developmentally at a kindergarten grade level of learning should be a type called "tamper-resistant electrical outlets." These types of outlets look like standard wall outlets but contain an internal shutter mechanism that prevents children from sticking objects like hairpins, keys, and paperclips into the receptacle (2). This spring-loaded shutter mechanism only opens when equal pressure is applied to both shutters such as when an electrical plug is inserted (2,3). In existing child care facilities that do not have "tamper-resistant electrical outlets," outlets should have "safety covers" that are attached to the electrical outlet by a screw or other means to prevent easy removal by a child. "Safety plugs" should not be used since they can be removed from	**290-2-3-.13 Building and Grounds.** (g) Multiple plugs and electric extension cords shall not be used. Electrical outlets within reach of children shall be plugged or covered.	Partially meets.	Rule does not contain GFCI.	DECAL should add the reference to GFCI.	

an electrical outlet by children (2,3). All newly installed or replaced electrical outlets that are accessible to children should use "tamper-resistant electrical outlets." In areas where electrical products might come into contact with water, a special type of outlet called Ground Fault Circuit Interrupters (GFCIs) should be installed (2). A GFCI is designed to trip before a deadly electrical shock can occur (1). To ensure that GFCIs are functioning correctly, they should be tested at least monthly (2). GFCIs are also available in a tamper-resistant design.					
STANDARD 5.2.4.4: Location of Electrical Devices Near Water No electrical device or apparatus accessible to children should be located so it could be plugged into an electrical outlet while a person is in contact with a water source, such as a sink, tub, shower area, water table, or swimming pool.		Not addressed.		DECAL may want to address this specific standard and add it to their rules.	
STANDARD 5.2.5.1: Smoke Detection Systems and Smoke Alarms In large and small family child care homes, smoke alarms that receive their operating power from the building electrical system or are of the wireless signal-monitored-alarm system type should be installed. Battery-operated smoke alarms should be permitted provided that the facility demonstrates to the fire inspector that testing, maintenance, and battery replacement programs ensure reliability of power to the smoke alarms and signaling of a monitored alarm when the battery is low and that retrofitting the facility to connect the smoke alarms to the electrical system would be costly and difficult to achieve. Facilities with smoke alarms that operate using power from the building electrical system should keep a supply of batteries and battery-operated detectors for use during power outages.	**290-2-3-.11 Health, Safety, and Discipline** (h) At least one UL Approved smoke detector shall be on each floor of the home and such detectors shall be maintained in working order. At least one 2-A:5-B:C fire extinguisher shall be kept in the child care area to be located no more than thirty feet from the kitchen. The extinguisher shall be maintained in working order and shall be inaccessible to the children.	Meets.			
STANDARD 5.2.7.6: Storage and Disposal of Infectious and Toxic Wastes Infectious and toxic wastes should be stored separately from other wastes, and should be disposed of in a manner		Not addressed.		DECAL may want to address this specific standard and add it to their rules.	

approved by the regulatory health authority.					
STANDARD 5.2.8.1: Integrated Pest Management Facilities should adopt an integrated pest management program (IPM) to ensure long-term, environmentally sound pest suppression through a range of practices including pest exclusion, sanitation and clutter control, and elimination of conditions that are conducive to pest infestations. IPM is a simple, common-sense approach to pest management that eliminates the root causes of pest problems, providing safe and effective control of insects, weeds, rodents, and other pests while minimizing risks to human health and the environment (2,4). Pest Prevention: Facilities should prevent pest infestations by ensuring sanitary conditions. This can be done by eliminating pest breeding areas, filling in cracks and crevices; holes in walls, floors, ceilings and water leads; repairing water damage; and removing clutter and rubbish on the premises (5). Pest Monitoring: Facilities should establish a program for regular pest population monitoring and should keep records of pest sightings and sightings of indicators of the presence of pests (e.g., gnaw marks, frass, rub marks). Pesticide Use: If physical intervention fails to prevent pest infestations, facility managers should ensure that targeted, rather than broadcast applications of pesticides are made, beginning with the products that pose least exposure hazard first, and always using a pesticide applicator who has the licenses or certifications required by state and local laws. Facility managers should follow all instructions on pesticide product labels and should not apply any pesticide in a manner inconsistent with label instructions. Material Safety Data Sheets (MSDS) are available from the product manufacturer or a licensed exterminator and should be on file at the facility Facilities should ensure that pesticides are never applied when children are present and that re-entry periods are adhered to. Records of all pesticides applications (including type and amount of pesticide used), timing and location of treatment, and results should be maintained either on-line or in a manner that permits access by facility managers and staff, state inspectors and regulatory personnel, parents/guardians, and others who may inquire about		Not addressed.		DECAL may want to address this specific standard and add it to their rules.	

pesticide usage at the facility. Facilities should avoid the use of sprays and other volatilizing pesticide formulations. Pesticides should be applied in a manner that prevents skin contact and any other exposure to children or staff members and minimizes odors in occupied areas. Care should be taken to ensure that pesticide applications do not result in pesticide residues accumulating on tables, toys, and items mouthed or handled by children, or on soft surfaces such as carpets, upholstered furniture, or stuffed animals with which children may come in direct contact (3). Following the use of pesticides, herbicides, fungicides, or other potentially toxic chemicals, the treated area should be ventilated for the period recommended on the product label. Notification: Notification should be given to parents/guardians and staff before using pesticides, to determine if any child or staff member is sensitive to the product. A member of the child care staff should directly observe the application to be sure that toxic chemicals are not applied on surfaces with which children or staff may come in contact. Registry: Child care facilities should provide the opportunity for interested staff and parents/guardians to register with the facility if they want to be notified about individual pesticide applications before they occur. Warning Signs: Child care facilities must post warning signs at each area where pesticides will be applied. These signs must be posted forty-eight hours before and seventy-two hours after applications and should be sufficient to restrict uninformed access to treated areas. Record Keeping: Child care facilities should keep records of pesticide use at the facility and make the records available to anyone who asks. Record retention requirements vary by state, but federal law requires records to be kept for two years (7). It is a good idea to retain records for a minimum of three years. Pesticide Storage: Pesticides should be stored in their original containers and in a locked room or cabinet accessible only to authorized staff. No restricted-use pesticides should be stored or used on the premises except by properly licensed persons. Banned, illegal, and unregistered pesticides should not be used.					

STANDARD 5.2.9.1: Use and Storage of Toxic Substances The following items should be used as recommended by the manufacturer and should be stored in the original labeled containers: a) Cleaning materials; b) Detergents; c) Automatic dishwasher detergents; d) Aerosol cans; e) Pesticides; f) Health and beauty aids; g) Medications; h) Lawn care chemicals; i) Other toxic materials. Material Safety Data Sheets (MSDS) must be available on-site for each hazardous chemical that is on the premises. These substances should be used only in a manner that will not contaminate play surfaces, food, or food preparation areas, and that will not constitute a hazard to the children or staff. When not in active use, all chemicals used inside or outside should be stored in a safe and secure manner in a locked room or cabinet, fitted with a child-resistive opening device, inaccessible to children, and separate from stored medications and food. Chemicals used in lawn care treatments should be limited to those listed for use in areas that can be occupied by children. Medications can be toxic if taken by the wrong person or in the wrong dose. Medications should be stored safely (see Standard 3.6.3.1) and disposed of properly (see Standard 3.6.3.2). The telephone number for the poison center should be posted in a location where it is readily available in emergency situations (e.g., next to the telephone). Poison centers are open twenty-four hours a day, seven days a week, and can be reached at 1-800-222-1222.		Not addressed.		DECAL may want to address this specific standard and add it to their rules.	
STANDARD 5.2.9.13: Testing for Lead In all centers, both exterior and interior surfaces covered by paint with lead levels of 0.06% and above, or equal to or greater than 1.0 milligram per square centimeter and accessible to children, should be removed by a safe chemical or		Not addressed.		DECAL may want to address this specific standard and add it to their rules.	

physical means or made inaccessible to children, regardless of the condition of the surface. In large and small family child care homes, flaking or deteriorating lead-based paint on any surface accessible to children should be removed or abated according to health department regulations. Where lead paint is removed, the surface should be refinished with lead-free paint or non-toxic material. Sanding, scraping, or burning of lead-based paint surfaces should be prohibited. Children and pregnant women should not be present during lead renovation or lead abatement activities. Any surface and the grounds around and under surfaces that children use at a child care facility, including dirt and grassy areas should be tested for excessive lead in a location designated by the health department. Caregivers/ teachers should check the U.S. Consumer Product Safety Commission's Website, http://www.cpsc.gov, for warnings of potential lead exposure to children and recalls of play equipment, toys, jewelry used for play, imported vinyl mini-blinds and food contact products. If they are found to have toxic levels, corrective action should be taken to prevent exposure to lead at the facility. Only nontoxic paints should be used.					
STANDARD 5.2.9.2: Use of a Poison Center The poison center should be called for advice about any exposure to toxic substances, or any potential poisoning emergency. The national help line for the poison center is 1-800-222-1222, and specialists will link the caregiver/ teacher with their local poison center. The advice should be followed and documented in the facility's files. The caregiver/teacher should be prepared for the call by having the following information for the poison center specialist: a) The child's age and sex; b) The substance involved; c) The estimated amount; d) The child's condition; e) The time elapsed since ingestion or exposure. The caregiver/teacher should not induce vomiting unless instructed by the poison center.		Not addressed.		DECAL may want to address this specific standard and add it to their rules.	
STANDARD 5.2.9.3: Informing Staff Regarding Presence of Toxic Substances		Not addressed.		DECAL may want to address this specific standard and add it to their	

Employers should provide staff with hazard information, including access to and review of the Material Safety Data Sheets (MSDS) as required by the Occupational Safety and Health Administration (OSHA), about the presence of toxic substances such as formaldehyde, cleaning and sanitizing supplies, insecticides, herbicides, and other hazardous chemicals in use in the facility. Staff should always read the label prior to use to determine safety in use. For example, toxic products regulated by the Environmental Protection Agency (EPA) will have an EPA signal word of CAUTION, WARNING, or DANGER. Where nontoxic substitutes are available, these nontoxic substitutes should be used instead of toxic chemicals. If a nontoxic product is not available, caregivers/teachers should use the least toxic product for the job. A CAUTION label is safer than a WARNING label, which is safer than a DANGER label.				rules.	
STANDARD 5.2.9.5: Carbon Monoxide Detectors Carbon monoxide detector(s) should be installed in child care settings if one of the following guidelines is met: a) The child care program uses any sources of coal, wood, charcoal, oil, kerosene, propane, natural gas, or any other product that can produce carbon monoxide indoors or in an attached garage; b) If detectors are required by state/local law or state licensing agency. Facilities must meet state or local laws regarding carbon monoxide detectors. Detectors should be tested monthly. Batteries should be changed at least yearly. Detectors should be replaced at least every five years.		Not addressed.		DECAL may want to address this specific standard and add it to their rules.	
STANDARD 5.3.1.12: Availability and Use of a Telephone or Wireless Communication Device The facility should provide at all times at least one working non-pay telephone or wireless communication device for general and emergency use: a) On the premises of the child care facility; b) In each vehicle used when transporting children; c) On field trips. Drivers, while transporting children should not operate a motor vehicle while using a mobile telephone or wireless communications device when the vehicle is in motion or a	**290-2-3-.11 Health, Safety, and Discipline** (b) An operable telephone shall be readily available in the home with the following telephone numbers posted in a conspicuous place next to the telephone. In those areas of the state serviced by the 911 emergency number, 911 may be posted in lieu of the phone numbers required for 2., 3., and 4. below: 1. A physician or hospital; 2. An ambulance or rescue squad service;	Partially meets and exceeds.	Within this rule it is met by requiring the phone and exceeds that standard by specifying numbers to be posted; but there is on mention about use and transportation.	DECAL may want to add the additional sections regarding use and lack of use during transporting children.	

part of traffic, with the exception of use of a navigational system or global positioning system device.	3. The local fire department; 4. The local police department; 5. The county health department; and 6. The regional poison control center.				
STANDARD 5.4.5.2: Cribs Facilities should check each crib before its purchase and use to ensure that it is in compliance with the current U.S. Consumer Product Safety Commission (CPSC) and ASTM safety standards. Recalled or "second-hand" cribs should not be used or stored in the facility. When it is determined that a crib is no longer safe for use in the facility, it should be dismantled and disposed of appropriately. Staff should only use cribs for sleep purposes and should ensure that each crib is a safe sleep environment. No child of any age should be placed in a crib for a time-out or for disciplinary reasons. When an infant becomes large enough or mobile enough to reach crib latches or potentially climb out of a crib, they should be transitioned to a different sleeping environment (such as a cot or sleeping mat). Each crib should be identified by brand, type, and/or product number and relevant product information should be kept on file (with the same identification information) as long as the crib is used or stored in the facility. Staff should inspect each crib before each use to ensure that hardware is tightened and that there are not any safety hazards. If a screw or bolt cannot be tightened securely, or there are missing or broken screws, bolts, or mattress support hangers, the crib should not be used. Safety standards document that cribs used in facilities should be made of wood, metal, or plastic. Crib slats should be spaced no more than two and three-eighths inches apart, with a firm mattress that is fitted so that no more than two fingers can fit between the mattress and the crib side in the lowest position. The minimum height from the top of the mattress to the top of the crib rail should be twenty inches in the highest position. Cribs with drop sides should not be used. The crib should not have corner post extensions (over one-sixteenth inch). The crib should have no cutout openings in the head board or footboard structure in which a child's head could become entrapped. The	**290-2-3-.19 Infant-Sleeping Safety .** If the crib has side bars, the bars will be no more than two and three-eights inches apart. Any crib used for sleeping shall have a tight fitting bottom crib sheet with no pillows, quilts, comforters, bumper pads, sheepskins, stuffed toys or other soft items in the crib.	Partially meets.	This rule does not address many of the key elements in the Stepping Stones standard and there is no reference to the CPSC or ASTM safety standards.	DECAL may want to add the reference to CPSC and ASTM safety standards and the specific language from Stepping Stones.	

mattress support system should not be easily dislodged from any point of the crib by an upward force from underneath the crib. All cribs should meet the ASTM F1169-10a Standard Consumer Safety Specification for Full-Size Baby Cribs, F406-10b Standard Consumer Safety Specification for Non-Full-Size Baby Cribs/Play Yards, or the CPSC 16 CFR 1219, 1220, and 1500 – Safety Standards for Full-Size Baby Cribs and Non-Full-Size Baby Cribs; Final Rule. Cribs should be placed away from window blinds or draperies. As soon as a child can stand up, the mattress should be adjusted to its lowest position. Once a child can climb out of his/her crib, the child should be moved to a bed. Children should never be kept in their crib by placing, tying, or wedging various fabric, mesh, or other strong coverings over the top of the crib. Cribs intended for evacuation purpose should be of a design and have wheels that are suitable for carrying up to five non-ambulatory children less than two years of age to a designated evacuation area. This crib should be used for evacuation in the event of fire or other emergency. The crib should be easily moveable and should be able to fit through the designated fire exit.					
STANDARD 5.5.0.6: Inaccessibility to Matches, Candles, and Lighters Matches, candles, and lighters should not be accessible to children.		Not addressed.		DECAL may want to address this specific standard and add it to their rules.	
STANDARD 5.5.0.7: Storage of Plastic Bags Plastic bags, whether intended for storage, trash, diaper disposal, or any other purpose, should be stored out of reach of children.		Not addressed.		DECAL may want to address this specific standard and add it to their rules.	
STANDARD 5.5.0.8: Firearms If present in a small or large family child care home, these items must be unloaded, equipped with child protective devices, and kept under lock and key with the ammunition locked separately in areas inaccessible to the children. Parents/guardians should be informed about this policy.	**290-2-3-.11 Health, Safety, and Discipline** (g) Firearms shall be stored so they are not accessible to children	Partially meets.	Rule states that firearms shall not be accessible to children but doesn't have the additional precautions.	Additional precautions should be added.	

STANDARD 6.1.0.3: Rooftops as Play Areas A rooftop used as a play area should be enclosed with a fence from four to six feet high, in accordance with local ordinance, and the bottom edge should be less than three and one-half inches from the base (1). The fence should be designed to prevent children from climbing it. An approved fire escape should lead from the roof to an open space at the ground level that meets the safety standards for outdoor play areas.		Not addressed.		DECAL may want to address this specific standard and add it to their rules.	
STANDARD 6.1.0.4: Elevated Play Areas Elevated play areas that have been created using a retaining wall should have a guardrail, protective barrier, or fence running along the top of the retaining wall. If the exposed side of the retaining wall is higher than two feet, a fence not less than six feet high should be installed. The bottom edge of the fence should be less than three and one-half inches from the base and should be designed to prevent children from climbing it. Fences should be de-signed so all spaces are less than three and one-half inches (1). If the height of the exposed side of the retaining wall is two feet or lower, a guardrail should be installed if caring for preschool and school-age children. The space between the bottom of the guardrail and the ground should be more than nine inches but less than or equal to twenty-three inches. For school-age children, the space between the bottom of the guardrail and the ground should be more than nine inches but less than or equal to twenty-eight inches. If caring for infants or toddlers, a protective barrier should be installed. The space between the barrier and the ground should be less than three and one-half inches and should be from four to six feet in height.		Not addressed.		DECAL may want to address this specific standard and add it to their rules.	
STANDARD 6.1.0.6: Location of Play Areas Near Bodies of Water Outside play areas should be free from the following bodies of water: a) Unfenced swimming and wading pools;		Not addressed.		DECAL may want to address this specific standard and add it to their rules.	

b) Ditches; c) Quarries; d) Canals; e) Excavations; f) Fish ponds; g) Water retention or detention basins; h) Other bodies of water.					
STANDARD 6.1.0.8: Enclosures for Outdoor Play Areas The outdoor play area should be enclosed with a fence or natural barriers. Fences and barriers should not prevent the observation of children by caregivers/teachers. If a fence is used, it should conform to applicable local building codes in height and construction. Fence posts should be outside the fence where allowed by local building codes. These areas should have at least two exits, with at least one being remote from the buildings. Gates should be equipped with self-closing and positive self-latching closure mechanisms. The latch or securing device should be high enough or of a type such that children cannot open it. The openings in the fence and gates should be no larger than three and one-half inches. The fence and gates should be constructed to discourage climbing. Play areas should be secured against inappropriate use when the facility is closed. Wooden fences and playground structures created out of wood should be tested for chromated copper arsenate (CCA). Wooden fences and playground structures created out of wood that is found to contain CCA should be sealed with an oil-based outdoor sealant annually.	**290-2-3-.13 Building and Grounds** (2) Outside grounds and play areas shall be kept clean and free of obvious hazards to the children's health and safety. (c) Such outside play areas shall be protected from traffic or other hazards by fencing or other barriers at least four feet in height and approved by the department. Fencing material shall not present a hazard to children. A fence shall be provided around swimming pools to make them inaccessible when not in use.	Partially meets.	No mention of self-closing or positive self-latching closure mechanisms. No mention about testing for CCA. No mention about having at least two exits.	DECAL should add the additional wording to this rule.	
STANDARD 6.2.3.1: Prohibited Surfaces for Placing Climbing Equipment Equipment used for climbing should not be placed over, or immediately next to, hard surfaces such as asphalt, concrete, dirt, grass, or flooring covered by carpet or gym mats not intended for use as surfacing for climbing equipment. All pieces of playground equipment should be placed over and surrounded by a shock-absorbing surface. This material may be either the unitary or the loose-fill type, as defined	**290-2-3-.13 Building and Grounds** (b) Climbing and swinging equipment that are not portable shall be securely anchored to eliminate accidents or injuries and have a resilient surface beneath the equipment and the fall zone from such equipment which is adequately maintained by the family day care home to assure continuing resiliency.	Partially meets.	Rule does not address the CPSC or ASTM standards.	DECAL should add the references to the CPSC and ASTM standards.	

by the U.S. Consumer Product Safety Commission (CPSC) guidelines and ASTM International (ASTM) standards, extending at least six feet beyond the perimeter of the stationary equipment. These shock-absorbing surfaces must conform to the standard stating that the impact of falling from the height of the structure will be less than or equal to peak deceleration of 200G and a Head Injury Criterion (HIC) of 1000 and should be maintained at all times. Organic materials that support colonization of molds and bacteria should not be used. All loose fill materials must be raked to retain their proper distribution, shock-absorbing properties and to remove foreign material. This standard applies whether the equipment is installed outdoors or indoors.					
STANDARD 6.2.4.4: Trampolines Trampolines, both full and mini-size, should be prohibited from being used as part of the child care program activities both on-site and during field trips.		Not addressed.		DECAL may want to address this specific standard and add it to their rules.	
STANDARD 6.2.5.1: Inspection of Indoor and Outdoor Play Areas and Equipment The indoor and outdoor play areas and equipment should be inspected daily for the following: a) Missing or broken parts; b) Protrusion of nuts and bolts; c) Rust and chipping or peeling paint; d) Sharp edges, splinters, and rough surfaces; e) Stability of handholds; f) Visible cracks; g) Stability of non-anchored large play equipment (e.g., playhouses); h) Wear and deterioration. Observations should be documented and filed, and the problems corrected. Facilities should conduct a monthly inspection.	**290-2-3-.13 Building and Grounds** (2) Outside grounds and play areas shall be kept clean and free of obvious hazards to the children's health and safety. (a) Outside play areas shall be free of hazards such as, but not limited to exposed sharp edges of concrete or equipment, broken glass, debris, open drainage ditches, holes and stagnant water.	Partially meets.	No mention of when observations are made and it should be done monthly.	DECAL should consider adding this minor addition.	
STANDARD 6.3.1.1: Enclosure of Bodies of Water	**290-2-3-.13 Building and Grounds** A fence shall be provided around	Partially meets.	Rule addresses having a fence but no specifications about	Specifications should be added.	

All water hazards, such as pools, swimming pools, stationary wading pools, ditches, fish ponds, and water retention or detention basins should be enclosed with a fence that is four to six feet high or higher and comes within three and one-half inches of the ground. Openings in the fence should be no greater than three and one-half inches. The fence should be constructed to discourage climbing and kept in good repair. If the fence is made of horizontal and vertical members (like a typical wooden fence) and the distance between the tops of the horizontal parts of the fence is less than forty-five inches, the horizontal parts should be on the swimming pool side of the fence. The spacing of the vertical members should not exceed one and three-quarters inches. For a chain link fence, the mesh size should not exceed one and one-quarter square inches. Exit and entrance points should have self-closing, positive latching gates with locking devices a minimum of fifty-five inches from the ground. A wall of the child care facility should not constitute one side of the fence unless the wall has no openings capable of providing direct access to the pool (such as doors, windows, or other openings). If the facility has a water play area, the following requirements should be met: a) Water play areas should conform to all state and local health regulations; b) Water play areas should not include hidden or enclosed spaces; c) Spray areas and water-collecting areas should have a non-slip surface, such as asphalt; d) Water play areas, particularly those that have standing water, should not have sudden changes in depth of water; e) Drains, streams, water spouts, and hydrants should not create strong suction effects or water-jet forces; f) All toys and other equipment used in and around the water play area should be made of sturdy plastic or metal (no glass should be permitted); g) Water play areas in which standing water is maintained for more than twenty-four hours should be treated according to Standard 6.3.4.1, and inspected for glass, trash, animal excrement, and other foreign material.	swimming pools to make them inaccessible when not in use.		the fence.		

STANDARD 6.3.1.2: Accessibility to Above- Ground Pools Above-ground pools should have non-climbable sidewalls that are at least four feet high or should be enclosed with an approved fence. When the pool is not in use, steps should be removed from the pool or otherwise protected to ensure that they cannot be accessed.	**290-2-3-.13 Building and Grounds** A fence shall be provided around swimming pools to make them inaccessible when not in use	Meets.	This rule addresses accessibility but does not contain the additional specificity regarding non-climbable sidewalls, fencing, or steps.	DECAL may want to add this specificity to the rule.	
STANDARD 6.3.1.4: Safety Covers for Swimming Pools When not in use, in-ground and above-ground swimming pools should be covered with a safety cover that meets or exceeds the ASTM International (ASTM) standard "F1346- 03: Standard performance specification for safety covers and labeling requirements for all covers for swimming pools, spas, and hot tubs" (2).		Not addressed.		DECAL may want to address this specific standard and add it to their rules.	
STANDARD 6.3.1.6: Pool Drain Covers All covers for the main drain and other suction ports of swimming and wading pools should be listed by a nation-ally recognized testing laboratory in accordance with ASME/ ANSI standard "A112.19.8: Standard for Suction Fittings for Use in Swimming Pools, Wading Pools, Spas and Hot Tubs," and should be used under conditions that do not exceed the approved maximum flow rate, be securely anchored using manufacturer-supplied parts installed per manufacturer's specifications, be in good repair, and be replaced at intervals specified by manufacturer. Facilities with one outlet per pump, or multiple outlets per pump with less than thirty-six inches center-to-center distance for two outlets, must be equipped with a Safety Vacuum Release System (SVRS) meeting the ASME/ANSI standard "A112.19.17: Manufactured Safety Vacuum Release Systems for Residential and Commercial Swimming Pool, Spas, Hot Tub and Wading Pool Suction Systems" or ASTM International (ASTM) standard "F2387-04: Standard Specification for Manufactured SVRS for Swimming Pools, Spas, and Hot Tubs" standards, as required by the *Virginia Graeme Baker Pool and Spa Safety Act*, Section 1404(c)(1)(A)(I) (1,2).		Not addressed.		DECAL may want to address this specific standard and add it to their rules.	

STANDARD 6.3.2.1: Lifesaving Equipment Each swimming pool more than six feet in width, length, or diameter should be provided with a ring buoy and rope, a rescue tube, or a throwing line and a shepherd's hook that will not conduct electricity. This equipment should be long enough to reach the center of the pool from the edge of the pool, should be kept in good repair, and should be stored safely and conveniently for immediate access. Caregivers/ teachers should be trained on the proper use of this equipment so that in emergencies, caregivers/teachers will use equipment appropriately. Children should be familiarized with the use of the equipment based on their developmental level.		Not addressed.		DECAL may want to address this specific standard and add it to their rules.	
STANDARD 6.3.5.1: Hot Tubs, Spas, and Saunas Children should not be permitted in hot tubs, spas, or saunas in child care. Areas should be secured to prevent any access by children.		Not addressed.		DECAL may want to address this specific standard and add it to their rules.	
STANDARD 6.3.5.2: Water in Containers Bathtubs, buckets, diaper pails, and other open containers of water should be emptied immediately after use.		Not addressed.		DECAL may want to address this specific standard and add it to their rules.	
STANDARD 6.4.1.2: Inaccessibility of Toys or Objects to Children Under Three Years of Age Small objects, toys, and toy parts available to children under the age of three years should meet the federal small parts standards for toys. The following toys or objects should not be accessible to children under three years of age: a) Toys or objects with removable parts with a diameter less than one and one-quarter inches and a length between one inch and two and one-quarter inches; b) Balls and toys with spherical, ovoid (egg shaped), or elliptical parts that are smaller than one and three-quarters inches in diameter; c) Toys with sharp points and edges;		Not addressed.		DECAL may want to address this specific standard and add it to their rules.	

d) Plastic bags; e) Styrofoam objects; f) Coins; g) Rubber or latex balloons; h) Safety pins; i) Marbles; j) Magnets; k) Foam blocks, books, or objects; l) Other small objects; m) Latex gloves; n) Bulletin board tacks; o) Glitter.					
STANDARD 6.4.1.5: Balloons Infants, toddlers, and preschool children should not be permitted to inflate balloons, suck on or put balloons in their mouths nor have access to uninflated or underinflated balloons. Children under eight should not have access to latex balloons or inflated latex objects that are treated as balloons and these objects should not be permitted in the child care facility.	**290-2-3-.12 Equipment and Supplies** balloons shall not be accessible to preschool children	Partially meets.	Rule does not address children under age eight.	DECAL may want to add this age range to this rule.	
STANDARD 6.4.2.2: Helmets All children one year of age and over should wear properly fitted and approved helmets while riding toys with wheels (tricycles, bicycles, etc.) or using any wheeled equipment (rollerblades, skateboards, etc.). Helmets should be re-moved as soon as children stop riding the wheeled toys or using wheeled equipment. Approved helmets should meet the standards of the U.S. Consumer Product Safety Com-mission (CPSC) (5). The standards sticker should be located on the bike helmet. Bike helmets should be replaced if they have been involved in a crash, the helmet is cracked, when straps are broken, the helmet can no longer be worn properly, or according to recommendations by the manufacturer (usually after three years).		Not addressed.		DECAL may want to address this specific standard and add it to their rules.	
STANDARD 6.5.1.1: Competence and Training of Transportation Staff At least one adult who accompanies or drives children for	**290-2-3-.11 Health, Safety, and Discipline** (j) If children are transported in an automobile by the provider or a home's	Partially meets.	The rule does not address training regarding first aid & CPR and does not address the other developmentally related	DECAL should consider adding the other developmentally related trainings and procedures.	

field trips and out-of-facility activities should receive training by a professional knowledgeable about child development and procedures, to ensure the safety of all children. The caregiver should hold a valid pediatric first aid certificate, including rescue breathing and management of blocked airways. Any emergency medications that a child might require, such as self-injecting epinephrine for life-threatening allergy, should also be available at all times as well as a mobile phone to call for medical assistance. Child:staff ratios should be maintained on field trips and during transport, the driver should not be included in these ratios. No child should ever be left alone in the vehicle. All drivers, passenger monitors, chaperones, and assistants should receive instructions in safety precautions. Transportation procedures should include: a) Use of developmentally appropriate safety restraints; b) Proper placement of the child in the motor vehicle in accordance with state and federal child restraint laws and regulations and recognized best practice; c) Training in handling of emergency medical situations. If a child has a chronic medical condition or special health care needs that could result in an emergency (such as asthma, diabetes, or seizures), the driver or chaperone should have written instructions including parent/guardian emergency contacts, child summary health information, special needs and treatment plans, and should: 1) Recognize the signs of a medical emergency; 2) Know emergency procedures to follow (3); 3) Have on hand any emergency supplies or medications necessary, properly stored out of reach of children; 4) Know specific medication administration (ex. a child who requires EpiPen or diazepam); 5) Know about water safety when field trip is to a location with a body of water. d) Knowledge of appropriate routes to emergency facility; e) Defensive driving; f) Child supervision during transport, including never leaving a child unattended in or around a vehicle; g) Issues that may arise in transporting children with	employee, the driver shall have a current driver's license and children shall be restrained by either individual seat belts or appropriate child restraints in accordance with state law. No child shall be left unattended in a motor vehicle.		trainings and procedures.		

behavioral issues (e.g., temper tantrums or oppositional behavior). The receipt of such instructions should be documented in a personnel record for any paid staff or volunteer who participates in field trips or transportation activities. Vehicles should be equipped with a first aid kit, fire extinguisher, seat belt cutter, and maps. At least one adult should have a functioning cell phone at hand. Information, names of the children and parent/guardian contact information should be carried in the vehicle along with identifying information (name, address, and telephone number) about the child care center.					
STANDARD 6.5.1.2: Qualifications for Drivers Any driver who transports children for a child care program should be at least twenty-one years of age and should have: a) A valid commercial driver's license that authorizes the driver to operate the vehicle being driven; b) Evidence of a safe driving record for more than five years, with no crashes where a citation was issued; c) No alcohol, prescription or over-the-counter medications, or other drugs associated with impaired ability to drive, within twelve hours prior to transporting children. Drivers should ensure that any prescription or over-the-counter drugs taken will not impair their ability to drive; d) No tobacco, alcohol, or drug use while driving; e) No criminal record of crimes against or involving children, child neglect or abuse, substance abuse, or any crime of violence; f) No medical condition that would compromise driving, supervision, or evacuation capability including fatigue and sleep deprivation; g) Valid pediatric CPR and first aid certificate if transporting children alone. The driver's license number and date of expiration, vehicle insurance information, and verification of current state vehicle inspection should be on file in the facility. The child care program should require drug testing when noncompliance with the restriction on the use of alcohol or	**290-2-3-.11 Health, Safety, and Discipline** (j) If children are transported in an automobile by the provider or a home's employee, the driver shall have a current driver's license and children shall be restrained by either individual seat belts or appropriate child restraints in accordance with state law.	Partially meets.	No mention in the rule about evidence of a safe driving record, no alcohol or other drugs associated with impaired ability to drive within 12 hours prior to transporting children, no criminal record of crimes against or involving children, no medical condition that would compromise driving.	DECAL should consider adding the Stepping Stones standards specific language.	

other drugs is suspected.					
STANDARD 6.5.2.2: Child Passenger Safety When children are driven in a motor vehicle other than a bus, school bus, or a bus operated by a common carrier, the following should apply: a) A child should be transported only if the child is restrained in developmentally appropriate car safety seat, booster seat, seat belt, or harness that is suited to the child's weight, age, and/or psychological development in accordance with state and federal laws and regulations and the child is securely fastened, according to the manufacturer's instructions, in a developmentally appropriate child restraint system. b) Age and size-appropriate vehicle child restraint systems should be used for children under eighty pounds and under four-feet-nine-inches tall and for all children considered too small, in accordance with state and federal laws and regulations, to fit properly in a vehicle safety belt. The child passenger restraint system must meet the federal motor vehicle safety standards contained in the Code of Federal Regulations, Title 49, Section 571.213 (especially Federal Motor Vehicle Safety Standard 213), and carry notice of such compliance. c) For children who are obese or overweight, it is important to find a car safety seat that fits the child properly. Caregivers/teachers should not use a car safety seat if the child weighs more than the seat's weight limit or is taller than the height limit. Caregivers/teachers should check the labels on the seat or manufacturer's instructions if they are unsure of the limits. Manufacturer's instructions that include these specifications can also be found on the manufacturer's Website. d) Child passenger restraint systems should be installed and used in accordance with the manufacturer's instructions and should be secured in back seats only. e) All children under the age of thirteen should be transported in the back seat of a car and each child not riding in an appropriate child restraint system (i.e., a child seat, vest, or booster seat), should	**290-2-3-.11 Health, Safety, and Discipline** (j) If children are transported in an automobile by the provider or a home's employee, the driver shall have a current driver's license and children shall be restrained by either individual seat belts or appropriate child restraints in accordance with state law. No child shall be left unattended in a motor vehicle	Partially meets.	Rule has statement about restrained by appropriate child restraints in accordance with state law but does not have any of the specific language of the Stepping Stones standard.	The specifics of the Stepping Stones standard related to child passenger safety should be added to this rule.	

have an individual lap-and-shoulder seat belt (2). f) For maximum safety, infants and toddlers should ride in a rear-facing orientation (i.e., facing the back of the car) until they are two years of age or until they have reached the upper limits for weight or height for the rear-facing seat, according to the manufacturer's instructions (1). Once their seat is adjusted to face forward, the child passenger must ride in a forward-facing child safety seat (either a convertible seat or a combination seat) until reaching the upper height or weight limit of the seat, in accordance with the manufacturer's instructions (10). Plans should include limiting transportation times for young infants to minimize the time that infants are sedentary in one place. g) A booster seat should be used when, according to the manufacturer's instructions, the child has outgrown a forward-facing child safety seat, but is still too small to safely use the vehicle seat belts (for most children this will be between four feet nine inches tall and between eight and twelve years of age) (1). h) Car safety seats, whether provided by the child's parents/guardians or the child care program, should be labeled with the child passenger's name and emergency contact information. i) Car safety seats should be replaced if they have been recalled, are past the manufacturer's "date of use" expiration date, or have been involved in a crash that meets the U.S. Department of Transportation crash severity criteria or the manufacturer's criteria for replacement of seats after a crash (3,11). j) The temperature of all metal parts of vehicle child restraint systems should be checked before use to prevent burns to child passengers. If the child care program uses a vehicle that meets the definition of a school bus and the school bus has safety restraints, the following should apply: a) The school bus should accommodate the placement of wheelchairs with four tie-downs affixed according to the manufactures' instructions in a forward-facing direction; b) The wheelchair occupant should be secured by a three-point tie restraint during transport; c) At all times, school buses should be ready to					

transport children who must ride in wheelchairs; d) Manufacturers' specifications should be followed to assure that safety requirements are met.					
STANDARD 6.5.2.4: Interior Temperature of Vehicles The interior of vehicles used to transport children should be maintained at a temperature comfortable to children. When the vehicle's interior temperature exceeds 82°F and providing fresh air through open windows cannot reduce the temperature, the vehicle should be air-conditioned. When the interior temperature drops below 65°F and when children are feeling uncomfortably cold, the interior should be heated. To prevent hyperthermia, all vehicles should be locked when not in use, head counts of children should be taken after transporting to prevent a child from being left unintentionally in a vehicle, and children should never be intentionally left in a vehicle unattended.		Not addressed.		DECAL may want to address this specific standard and add it to their rules.	
STANDARD 6.5.3.1: Passenger Vans Child care facilities that provide transportation to children, parents/guardians, staff, and others should avoid the use of fifteen-passenger vans whenever possible. Other vehicles, such as vehicles meeting the definition of a "school bus," should be used to fulfill transportation of child passengers in particular. Conventional twelve- to fifteen-passenger vans cannot be certified as school buses by the National Highway Traffic Safety Administration (NHTSA) standards (2,4), and thus cannot be sold or leased, as new vehicles, to carry students on a regular basis. Caregivers/teachers should be knowledgeable about the laws of the state(s) in which their vehicles, including passenger vans, will be registered and used.		Not addressed.		DECAL may want to address this specific standard and add it to their rules.	
STANDARD 7.2.0.2: Unimmunized Children If immunizations have not been or are not to be administered because of a medical condition (contraindication), a statement from the child's primary care provider documenting the reason why the child is temporarily or permanently medically exempt from the immunization requirements should be on file. If immunizations are not to be administered because of the parents/guardians' religious	**290-2-3-.11 Health, Safety, and Discipline.** (b) Age appropriate immunization, or an affidavit or physician's statement as described in Rule .08(1)(c), shall be required for each preschool age child upon admission to the home or within 30 days thereafter	Meets.			

or philosophical beliefs, a legal exemption with notarization, waiver or other state-specific required documentation signed by the parent/guardian should be on file (1,2). The parent/guardian of a child who has not received the age-appropriate immunizations prior to enrollment and who does not have documented medical, religious, or philosophical exemptions from routine childhood immunizations should provide documentation of a scheduled appointment or arrangement to receive immunizations. This could be a scheduled appointment with the primary care provider or an upcoming immunization clinic sponsored by a local health department or health care organization. An immunization plan and catch-up immunizations should be initiated upon enrollment and completed as soon as possible according to the "Recommended Immunization Schedules for Persons Aged 0 Through 18 Years – United States, 2011" from the Advisory Committee on Immunization Practices (ACIP), the American Academy of Pediatrics (AAP), and the American Academy of Family Physicians (AAFP). Parents/guardians of children who attend an unlicensed child care facility should be encouraged to comply with the "Recommended Immunization Schedules" (6). If a vaccine-preventable disease to which children are susceptible occurs in the facility and potentially exposes the unimmunized children who are susceptible to that disease, the health department should be consulted to determine whether these children should be excluded for the duration of possible exposure or until the appropriate immunizations have been completed. The local or state health department will be able to provide guidelines for exclusion requirements.					
STANDARD 7.2.0.3: Immunization of Caregivers/Teachers Caregivers/teachers should be current with all immunizations routinely recommended for adults by the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC) as shown in the "Recommended Adult Immunization Schedule" at http://www.cdc.gov/vaccines/recs/schedules/default.htm#adult/. This schedule is updated annually at the beginning of the calendar year and can be found in Appendix H.		Not addressed.		DECAL may want to address this specific standard and add it to their rules.	

Caregivers/teachers should have received the recommended vaccines in the following categories: (1,2) a) Vaccines recommended for all adults who meet the age requirements and who lack evidence of immunity (i.e., lack documentation of vaccination or have no evidence of prior infection): 1) Tdap/Td; 2) Varicella-zoster; 3) MMR (measles, mumps, and rubella); 4) Seasonal influenza; 5) Human papillomaviruses (HPV) (eleven through twenty-six years of age); 6) Others as determined by the ACIP and state and local public health authorities. b) Recommended if a specific risk factor is present: 1) Pneumococcal; 2) Hepatitis A; 3) Hepatitis B; 4) Meningococcal; 5) Others as determined by the ACIP and state and local public health authorities. c) If a staff member is not appropriately immunized for medical, religious or philosophical reasons, the child care facility should require written documentation of the reason. d) If a vaccine-preventable disease to which adults are susceptible occurs in the facility and potentially exposes the unimmunized adults who are susceptible to that disease, the health department should be consulted to determine whether these adults should be excluded for the duration of possible exposure or until the appropriate immunizations have been completed. The local or state health department will be able to provide guidelines for exclusion requirements.					
STANDARD 7.3.3.1: Influenza Immunizations for Children and Caregivers/Teachers The parent/guardian of each child six months of age and older should provide written documentation of current annual vaccination against influenza unless there is a medical contraindication or philosophical or religious objection. Children who are too young to receive influenza vaccine before the start of influenza season should be immunized		Not addressed.		DECAL may want to address this specific standard and add it to their rules.	

annually beginning when they reach six months of age. Staff caring for all children should receive annual vaccination against influenza. Ideally people should be vaccinated before the start of the influenza season (as early as August or September) and immunization should continue through March or April.					
STANDARD 7.3.3.2: Influenza Control When influenza is circulating in the community, facilities should encourage parents/guardians to keep children with symptoms of acute respiratory tract illness with fever at home until their fever has subsided for at least twenty-four hours without use of fever reducing medication. Caregivers/teachers with symptoms of acute respiratory tract illness with fever also should remain at home until their fever subsides for at least twenty-four hours.		Not addressed.		DECAL may want to address this specific standard and add it to their rules.	
STANDARD 7.3.5.1: Recommended Control Measures for Invasive Meningococcal Infection in Child Care Identification of an individual with invasive meningococcal infection in the child care setting should result in the following: a) Immediate notification of the local or state health department; b) Notification of parents/guardians about child care contacts to the person with invasive meningococcal infection; c) Assistance with provision of antibiotic prophylaxis and vaccine receipt, as advised by the local or state health department, to child care contacts; d) Frequent updates and communication with parents/ guardians, health care professionals, and local health authorities.		Not addressed.		DECAL may want to address this specific standard and add it to their rules.	
STANDARD 7.3.5.2: Informing Public Health Authorities of Meningococcal Infections Meningococcal disease is designated as notifiable at the national level, and local and/or state public health department authorities should be notified immediately about the occurrence of invasive meningococcal disease in a child		Not addressed.		DECAL may want to address this specific standard and add it to their rules.	

care facility. Timely reporting results in early recognition of outbreaks and prevention of additional infections. Facilities should cooperate with their local or state health department officials in notifying parents/guardians of children who attend the facility about exposures to children with invasive meningococcal infections. Early intervention minimizes anxiety and concern that may result from identification of an attendee with an invasive meningococcal infection. This may include providing local health officials with the names and telephone numbers of parents/guardians of children in involved classrooms or facilities.					
STANDARD 7.3.9.1: Immunization with *Streptococcus Pneumoniae* Conjugate Vaccine (PCV13) Pneumococcal conjugate (PCV13) vaccine is recommended for all children from two through fifty-nine months of age, including children in child care facilities. The vaccine is recommended to be administered at two, four, six, and twelve through fifteen months of age (1-3,5). Healthy children between twenty-four and fifty-nine months of age who are not immunized completely for their age should be administered one dose of PCV13 (3,5). Children two years of age or older at high risk of invasive disease caused by *Streptococcus pneumoniae* (including sickle cell disease, asplenia, HIV, chronic illness, cochlear implant or immunocompromised) who have received their recommended doses of PCV should receive *S. pneumoniae* polysaccharide vaccine two or more months after receipt of the last dose of PCV (1-3,5).		Not addressed.		DECAL may want to address this specific standard and add it to their rules.	
STANDARD 7.4.0.1: Control of Enteric (Diarrheal) and Hepatitis A Virus (HAV) Infections Facilities should employ the following procedures, in addition to those stated in Child and Staff Inclusion/Exclusion/ Dismissal, Standards 3.6.1.1-3.6.1.4, to prevent and control infections of the gastrointestinal tract (including diarrhea) or hepatitis A (1-3): a) Toilet trained children who cannot use a toilet		Not addressed.		DECAL may want to address this specific standard and add it to their rules.	

for all bowel movements while attending the facility and who develop diarrhea, as defined in Standard 3.6.1.1, should be removed from the facility by their parent/ guardian. Exclude diapered children if stool is not contained in the diaper, stool frequency exceeds two or more stools above normal for that child, blood or mucus in the stool, abnormal color of stool, no urine output in eight hours, jaundice, fever with behavior change, or looks or acts ill. Pending arrival of the parent/guardian, the child should not be permitted to have contact with other children or be placed in areas used by adults who have contact with children in the facility. This should be accomplished by removing the child who is ill to a separate area of the child care program or, if not possible, to a separate area of the child's room. The area should be one where the child is supervised by an adult known to the child, and where the toys, equipment, and surfaces will not be used by other children or adults until after the child who is ill leaves and after the surfaces and toys have been disinfected. When moving a child to a separate area of the facility creates problems with supervision of the other children, as occurs in small family child care homes, the child who is ill should be kept as comfortable as possible, with minimal contact between children who are ill and well children, until the parent/guardian arrives. Caregivers/teachers with diarrhea as defined in Standard 3.6.1.2 should be excluded. Separation and exclusion of children or caregivers/teachers should not be deferred pending health assessment or laboratory testing to identify an enteric pathogen. b) A child who develops jaundice (when skin and white parts of the eye are yellow) while attending child care should be separated from other children and the child's parent/guardian should be contacted to remove the child. The child should remain separated from other children as described above until the parent/guardian arrives and removes the child from the facility. c) Exclusion for diarrhea should continue until either the diarrhea stops or the continued loose stools are deemed not to be infectious by a licensed health care professional. Exclusion for					

hepatitis A virus (HAV) should continue for one week after onset of jaundice. d) Alternate care for children with diarrhea or hepatitis A in special facilities for children who are ill should be provided in facilities that can provide separate care for children with infections of the gastrointestinal tract (including diarrhea) or hepatitis A. e) Children and caregivers/teachers who excrete intestinal pathogens but no longer have diarrhea generally may be allowed to return to child care once the diarrhea resolves, except for the case of infections with *Shigella*, Shiga toxin-producing *E. coli* (STEC),or Salmonella enterica serotype Typhi. For *Shigella* and STEC, resolution of symptoms and two negative stool cultures are required for readmission, unless state requirements differ. For *Salmonella* serotype Typhi, resolution of symptoms and three negative stool cultures are required for return to child care. For Salmonella species other than serotype Typhi, documentation of negative stool cultures are not required from asymptomatic people for readmission to child care. f) The local health department should be informed immediately of the occurrence of HAV infection or an increased frequency of diarrheal illness in children or staff in a child care facility. g) Recommended post-exposure prophylaxis for hepatitis A includes administration of hepatitis A vaccine or immune globulin to all previously unimmunized staff members and attendees of a child care facility in which a person with hepatitis A is identified. h) If there has been an exposure to a person with hepatitis A or diarrhea in the child care facility, caregivers/teachers should inform parents/guardians, in cooperation with the health department, that their children may have been exposed to children with HAV infection or to another person with a diarrheal illness.					
STANDARD 7.5.10.1: *Staphylococcus Aureus* Skin Infections Including MRSA The following should be implemented when children or		Not addressed.		DECAL may want to address this specific standard and add it to their rules.	

staff with lesions suspicious for *Staphylococcus aureus* infections are identified: a) Lesions should be covered with a dressing; b) Report the lesions to the parent/guardian with a recommendation for evaluation by a primary care provider; c) Exclusion is not warranted unless the individual meets any of the following criteria: 1) Care for other children would be compromised by care required for the person with the *S. aureus* infection; 2) The individual with the *S. aureus* infection has fever or a change in behavior; 3) The lesion(s) cannot be adequately covered by a bandage or the bandage needs frequent changing; 4) A health care professional or health department official recommends exclusion of the person with *S. aureus* infection. Meticulous hand hygiene following contact with lesions should be practiced. Careful hand hygiene and sanitization of surfaces and objects potentially exposed to infectious material are the best ways to prevent spread. Children and staff in close contact with an infected person should be observed for symptoms of *S. aureus* infection and referred for evaluation, if indicated. A child may return to group child care when staff members are able to care for the child without compromising their ability to care for others, the child is able to participate in activities, appropriate therapy is being given, and the lesions can be covered. *S. aureus* skin infections initially may appear as red raised areas that may become pus-filled abscesses or "boils," surrounded by areas of redness and tenderness. Fever and other symptoms including decreased activity, bone and joint pain, and difficulty breathing may occur when the infection occurs in other body systems. If any of these signs or symptoms occur, the child should be evaluated by his/her primary care provider.					
STANDARD 7.5.6.1: Immunization for Measles All children in a child care facility should have received		Not addressed.		DECAL may want to address this specific standard and add it to their rules.	

age-appropriate immunizations with measles, mumps, and rubella (MMR) vaccine or with measles, mumps, rubella, and varicella (MMRV) vaccine (1). If a case of measles occurs in a child care setting, interrupting subsequent spread depends on prompt immunization of people at risk of exposure or people already exposed who cannot provide documentation of measles immunity, including date of immunization. Children and adults in child care who are not immunized or not age-appropriately immunized against measles should be excluded from care immediately if the child care facility has been notified of a documented case of measles occurring in a child or adult in the center. These children should not be allowed to return to the facility until at least two weeks after the onset of rash in the last case of measles, as determined by health department officials. Adults born before 1957 can be considered immune to measles. Adults born during or after 1957 should receive one or more doses of MMR vaccine unless they have a medical contraindication, documentation of one or more dose of vaccine, history of measles based on primary care provider diagnosis, or laboratory evidence of immunity.					
STANDARD 9.2.3.12: Infant Feeding Policy A policy about infant feeding should be developed with the input and approval from the nutritionist/registered dietitian and should include the following: a) Storage and handling of expressed human milk; b) Determination of the kind and amount of commercially prepared formula to be prepared for infants as appropriate; c) Preparation, storage, and handling of infant formula; d) Proper handwashing of the caregiver/teacher and the children; e) Use and proper sanitizing of feeding chairs and of mechanical food preparation and feeding devices, including blenders, feeding bottles, and food warmers; f) Whether expressed human milk, formula, or infant food should be provided from home, and if so, how much food preparation and use of feeding devices, including blenders, feeding bottles, and food warmers, should be the responsibility of the caregiver/teacher;		Not addressed.		DECAL may want to address this specific standard and add it to their rules.	

g) Holding infants during bottle-feeding or feeding them sitting up; h) Prohibiting bottle propping during feeding or prolonging feeding; i) Responding to infants' need for food in a flexible fashion to allow cue feedings in a manner that is consistent with the developmental abilities of the child (policy acknowledges that feeding infants on cue rather than on a schedule may help prevent obesity) (1,2); j) Introduction and feeding of age-appropriate solid foods (complementary foods); k) Specification of the number of children who can be fed by one adult at one time; l) Handling of food intolerance or allergies (e.g., cow's milk, peanuts, orange juice, eggs, wheat). Individual written infant feeding plans regarding feeding needs and feeding schedule should be developed for each infant in consultation with the infant's primary care provider and parents/guardians.					
STANDARD 9.2.3.15: Policies Prohibiting Smoking, Tobacco, Alcohol, Illegal Drugs, and Toxic Substances Facilities should have written policies addressing the use and possession of tobacco products, alcohol, illegal drugs, prescription medications that have not been prescribed for the user, and unauthorized potentially toxic substances. Policies should include that all of these substances are prohibited inside the facility, on facility grounds, and in any vehicles that transport children at all times. Policies should specify that smoking is prohibited at all times and in all areas used by the children in the program. Smoking is also prohibited in any vehicles that transport children. Policies must also specify that use and possession of all substances referred to above is prohibited during all times when caregivers/teachers are responsible for the supervision of children, including times when children are transported, when playing in outdoor play areas not attached to the facility, and during field trips. Child care centers and large family child care homes should provide information to employees about available drug, alcohol, and tobacco counseling and rehabilitation, and any available employee assistance programs.	**290-2-3-.11 Health, Safety, and Discipline** (l)When children are present for care, providers, employees, and any other persons shall not smoke or use tobacco except in areas which are totally separated from areas used for child care. If smoking occurs in other areas of the home, the provider shall so advise parent or guardian.	Partially meets.	Rule addresses the prohibited substances but doesn't address the policies.	DECAL may or may not want to address the issue of policies.	

STANDARD 9.2.3.2: Content and Development of the Plan for Care of Children and Staff Who Are Ill All child care facilities should have written policies for the management and care of children and staff who are ill. The facility's plan for the care of children and staff who are ill should be developed in consultation with the facility's child care health consultant and other health care professionals to address current understanding of the technical issues of contagion and other health risks. This plan should include: a) Policies and procedures for urgent and emergency care; b) Admission and inclusion/exclusion policies; c) A description of illnesses common to children in child care, their management, and precautions to address the needs and behavior of the child who is ill, as well as to protect the health of other children and staff; d) A procedure to obtain and maintain updated individual care plans for children and staff with special health care needs; e) A procedure for documenting the name of person affected, date and time of illness, a description of symptoms, the response of the caregiver/teacher or other staff to these symptoms, who was notified (such as a parent/guardian, primary care provider, nurse, physician, or health department), and the response; f) Medication policy; g) Seasonal and pandemic influenza policy; h) Staff illness-guidelines for exclusion and re-entry. In group care, the facility should address the well-being of all those affected by illness: the child, the staff, parents/ guardians of the child, other children in the facility and their parents/guardians, and the community. The priority of the policy should be to meet the needs of the child who is ill and the other children in the facility. The policy should address the circumstances under which separation of the affected individual (child or staff person) from the group is required; the circumstances under which the staff, parents/guardians, or other designated persons need to be informed; and the procedures to be followed in these cases. The policy should take into consideration:		Not addressed.		DECAL may want to address this specific standard and add it to their rules.	

a) The physical facility; b) The number and the qualifications of the facility's personnel; c) The fact that children do become ill frequently and at unpredictable times; d) The fact that adults may be on staff with known health problems or may develop health problems while at work; e) The fact that working parents/guardians often are not given leave for their children's illnesses; f) The amount of care the child who is ill requires if the child remains in the program, can staff devote the time for caring of a child who is ill in the classroom without leaving other children unattended, and can the child participate in any of the classroom activities					
STANDARD 9.2.3.9: Written Policy on Use of Medications The facility should have a written policy for the administration of any prescription or non-prescription (over-the-counter [OTC]) medication. The policy should address at least the following: a) The use of written parental/guardian consent forms for each prescription and OTC medication to be administered at the child care facility. The consent form should include: 1) The child's name; 2) The name of the medication; 3) The date(s) and times the medication is to be given; 4) The dose or amount of medication to be given; 5) How the medication is to be administered; 6) The period of time the consent form is valid, which may not exceed the length of time the medication is prescribed for, the expiration date of the medication or one year, whichever is less. b) The use of the prescribing health professional's authorization forms for each prescription and OTCmedication to be administered at the child care facility. c) The circumstances under which the facility will agree to administer medication. This may include	**290-2-3-.08 Children's Records** (c) The policies and procedures shall also include written procedures for the following: 3. Administering medication and recording noticeable adverse reactions to medication; **290-2-3-.11 Health, Safety, and Discipline** (e) Except for first aid, personnel shall not dispense prescription or nonprescription medications to a child without specific written authorization from the child's physician, parent or guardian. All medications shall be stored in accordance with the prescription or label instructions and kept in places that are inaccessible to children. Each dose of medication given to a child shall be documented showing the child's name, name of medication, date and time given, and the name of the person giving the medication.	Partially meets.	Rule does not contain all the key elements to be present in the written policy.	DECAL may want to add the specific language from the Stepping Stones standard on written policy regarding the use of medications.	

the administration of: 1) Topical medications such as non-medicated diaper creams, insect repellants, and sun screens; 2) OTC medicines for fever including acetaminophen and ibuprofen; 3) Long-term medications that are administered daily for children with chronic health conditions that are managed with medications; 4) Controlled substances, such as psychotropic medications; 5) Emergency medications for children with health conditions that may become life-threatening such as asthma, diabetes, and severe allergies; 6) One-time medications to prevent conditions such as febrile seizures. d) The circumstances under which the facility will not administer medication. This should include: 1) No authorization from parent/guardian and/or prescribing health professional; 2) Prohibition of administering OTC cough and cold medication; 3) Not administering a new medication for the first time to a child while he or she is in child care; 4) If the instructions are unclear or the supplies needed to measure doses or administer the medication are not available or not in good working condition; 5) The medication has expired; 6) If a staff person or his/her backup who has been trained to give that particular medication is not present (in the case of training for medications that require specific skills to administer properly, such as inhalers, injections, or feeding tubes/ports). e) The process of accepting medication from parents/ guardians. This should include: 1) Verifying the consent form; 2) Verifying the medication matches what is on the consent form; 3) Accepting authorization for prescription medications from the child's prescribing health professional only if the medications are in their original container and have the child's name, the name of the medication, the dose and					

directions for giving the medication, the expiration date of the medication, and a list of warnings and possible side effects; 4) Accepting authorization for OTC medications from the child's prescribing health professional only if the authorization indicates the purpose of the medication and time intervals of administration, and if the medications are in their original container and include the child's name, the name of the medication, dose and directions for use, an expiration date for the medication, and a list of warnings and possible side effects; 5) Verifying that a valid Care Plan accompanies all long-term medications (i.e., medications that are to be given routinely or available routinely for chronic conditions such as asthma, allergies, and seizures); 6) Verifying any special storage requirements and any precautions to take while the child is on the prescription or OTC medication. f) The proper handling and storage of medications, including: 1) Emergency medications – totally inaccessible to children but readily available to supervising caregivers/teachers trained to give them; 2) Medications that require refrigeration; 3) Controlled substances; 4) Expired medications; 5) A policy to insure confidentiality; 6) Storing and preparing distribution in a quiet area completely out of access to children; 7) Keeping all medication at all times totally inaccessible to children (e.g., locked storage); 8) Whether to require even short-term medications be kept at the facility overnight. g) The procedures to follow when administering medications. These should include: 1) Assigning administration only to an adequately trained, designated staff; 2) Checking the written consent form; 3) Adhering to the "six rights" of safe medication administration (child, medication, time/date, dose, route, and documentation) (1); 4) Documenting and reporting any medication errors; 5) Documenting and reporting and adverse					

effects of the medication; 6) Documenting and reporting whether the child vomited or spit up the medication. h) The procedures to follow when returning medication to the family, including: 1) An accurate account of controlled substances being administered and the amount being returned to the family; 2) When disposing of unused medication, the remainder of a medication, including controlled substances. i) The disposal of medications that cannot be returned to the parent/guardian. A medication administration record should be maintained on an ongoing basis by designated staff and should include the following: a) Specific, signed parental/guardian consent for the caregiver/teacher to administer medication including documentation of receiving controlled substances and verification of the amount received; b) Specific, signed authorization from the child's prescribing health professional, prescribing the medication, including medical need, medication, dosage, and length of time to give medication. c) Information about the medication including warnings and possible side effects; d) Written documentation of administration of medication and any side effects; e) Medication errors log. The facility should consult with the State Board of Nursing, other interested organizations and their child care health consultant about required training and documentation for medication administration. Based on the information, the facility should develop and implement a plan regarding medication administration training.					
STANDARD 9.2.4.1: Written Plan and Training for Handling Urgent Medical Care or Threatening Incidents The facility should have a written plan for reporting and managing what they assess to be an incident or unusual occurrence that is threatening to the health, safety, or welfare of the children, staff, or volunteers. The facility should also include procedures of staff training on this plan. The management, documentation, and reporting of the fol-	**290-2-3-.08 Children's Records** (d) Written authorization for the child to receive emergency medical treatment when the parent or guardian is not available.	Partially meets.	The rule addresses written authorization but does not address a written plan and what it should contain.	The details of the written plan should be added to this rule.	

lowing types of incidents, at a minimum, that occur at the child care facility should be addressed in the plan: a) Lost or missing child; b) Suspected maltreatment of a child (also see state's mandates for reporting); c) Suspected sexual, physical, or emotional abuse of staff, volunteers, or family members occurring while they are on the premises of the child care facility; d) Injuries to children requiring medical or dental care; e) Illness or injuries requiring hospitalization or emergency treatment; f) Mental health emergencies; g) Health and safety emergencies involving parents/ guardians and visitors to the program; h) Death of a child or staff member, including a death that was the result of serious illness or injury that occurred on the premises of the child care facility, even if the death occurred outside of child care hours; i) The presence of a threatening individual who attempts or succeeds in gaining entrance to the facility. The following procedures, at a minimum, should be addressed in the plan for urgent care: a) Provision for a caregiver/teacher to accompany a child to a source of urgent care and remain with the child until the parent/guardian assumes responsibility for the child; b) Provision for the caregiver/teacher to provide the medical care personnel with an authorization form signed by the parent/guardian for emergency medical care and a written informed consent form signed by the parent/guardian allowing the facility to share the child's health records with other service providers; c) Provision for a backup caregiver/teacher or substitute for large and small family child care homes to make the arrangement for urgent care feasible (child:staff ratios must be maintained at the facility during the emergency); d) Notification of parent/guardian(s); e) Pre-planning for the source of urgent medical and dental care (such as a hospital emergency room, medical or dental clinic, or other constantly					

staffed facility known to caregivers/teachers and acceptable to parents/guardians); f) Completion of a written incident/injury report and the program's response; g) Assurance that the first aid kits are resupplied following each first aid incident, and that required contents are maintained in a serviceable condition, by a monthly review of the contents; h) Policy for scheduled reviews of staff members' ability to perform first aid for averting the need for emergency medical services; i) Policy for staff supervision following an incident when a child is lost, missing, or seriously injured.					
STANDARD 9.2.4.3: Disaster Planning, Training, and Communication Facilities should consider how to prepare for and respond to emergency or natural disaster situations and develop written plans accordingly. All programs should have procedures in place to address natural disasters that are relevant to their location (such as earthquakes, tornados, tsunamis or flash floods, storms, and volcanoes) and all hazards/disasters that could occur in any location including acts of violence, bioterrorism/terrorism, exposure to hazardous agents, facility damage, fire, missing child, power outage, and other situations that may require evacuation, lock-down, or shelter-in-place. **Written Emergency/Disaster Plan:** Facilities should develop and implement a written plan that describes the practices and procedures they use to prepare for and respond to emergency or disaster situations. This Emergency/Disaster Plan should include: a) Information on disasters likely to occur in or near the facility, county, state, or region that require advance preparation and/or contingency planning; b) Plans (and a schedule) to conduct regularly scheduled practice drills within the facility and in collaboration with community or other exercises; c) Mechanisms for notifying and communicating with parents/guardians in various situations (e.g., Website postings; email notification; central telephone number, answering machine, or answering service messaging; telephone calls, use of telephone tree, or cellular phone texts; and/or	**290-2-3-.11 Health, Safety, and Discipline** (2) Safety. (a) A home shall have a written plan for handling emergencies, including but not limited to fire, severe weather, loss of electrical power or water, and death, serious injury or loss of a child, which may occur at the home.	Partially meets.	Requirement for a written plan but no details.	Add the details from the Stepping Stones standard.	

posting of flyers at the facility and other community locations); d) Mechanisms for notifying and communicating with emergency management public officials; e) Information on crisis management (decision-making and practices) related to sheltering in place, relocating to another facility, evacuation procedures including how non-mobile children and adults will be evacuated, safe transportation of children including children with special health care needs, transporting necessary medical equipment obtaining emergency medical care, responding to an intruder, etc.; f) Identification of primary and secondary meeting places and plans for reunification of parents/ guardians with their children; g) Details on collaborative planning with other groups and representatives (such as emergency management agencies, other child care facilities, schools, emergency personnel and first responders, pediatricians/health professionals, public health agencies, clinics, hospitals, and volunteer agencies including Red Cross and other known groups likely to provide shelter and related services); h) Continuity of operations planning, including backing up or retrieving health and other key records/files and managing financial issues such as paying employees and bills during the aftermath of the disaster; i) Contingency plans for various situations that address: 1) Emergency contact information and procedures; 2) How the facility will care for children and account for them, until the parent/guardian has accepted responsibility for their care; 3) Acquiring, stockpiling, storing, and cycling to keep updated emergency food/water and supplies that might be needed to care for children and staff for up to one week if shelter-in-place is required and when removal to an alternate location is required; 4) Administering medicine and implementing other instructions as described in individual special care plans; 5) Procedures that might be implemented in the					

event of an outbreak, epidemic, or other infectious disease emergency (e.g., reviewing relevant immunization records, keeping symptom records, implementing tracking procedures and corrective actions, modifying exclusion and isolation guidelines, coordinating with schools, reporting or responding to notices about public health emergencies); 6) Procedures for staff to follow in the event that they are on a field trip or are in the midst of transporting children when an emergency or disaster situation arises; 7) Staff responsibilities and assignment of tasks (facilities should recognize that staff can and should be utilized to assist in facility preparedness and response efforts, however, they should not be hindered in addressing their own personal or family preparedness efforts, including evacuation). Details in the Emergency/Disaster Plan should be reviewed and updated bi-annually and immediately after any relevant event to incorporate any best practices or lessons learned into the document. Facilities should identify in advance which agency or agencies would be the primary contact for them regarding child care regulations, evacuation instructions, and other directives that might be communicated in various emergency or disaster situations. **Training:** Staff should receive training on emergency/disaster planning and response. Training should be provided by emergency management agencies, educators, child care health consultants, health professionals, or emergency personnel qualified and experienced in disaster preparedness and response. The training should address: a) Why it is important for child care facilities to prepare for disasters and to have an Emergency/Disaster Plan; b) Different types of emergency and disaster situations and when and how they may occur; 1) Natural Disasters; 2) Terrorism (i.e., biological, chemical, radiological, nuclear); 3) Outbreaks, epidemics, or other infectious disease emergencies;					

c) The special and unique needs of children, appropriate response to children's physical and emotional needs during and after the disaster, including information on consulting with pediatric disaster experts; d) Providing first aid, medications, and accessing emergency health care in situations where there are not enough available resources; e) Contingency planning including the ability to be flexible, to improvise, and to adapt to ever-changing situations; f) Developing personal and family preparedness plans; g) Supporting and communicating with families; h) Floor plan safety and layout; i) Location of emergency documents, supplies, medications, and equipment needed by children and staff with special health care needs; j) Typical community, county, and state emergency procedures (including information on state disaster and pandemic influenza plans, emergency operation centers, and incident command structure); k) Community resources for post-event support such as mental health consultants, safety consultants; l) Which individuals or agency representatives have the authority to close child care programs and schools and when and why this might occur; m) Insurance and liability issues; n) New advances in technology, communication efforts, and disaster preparedness strategies customized to meet children's needs. **Communicating with Parents/Guardians:** Facilities should share detailed information about facility disaster planning and preparedness with parents/guardians when they enroll their children in the program, including: a) Portions of the Emergency/Disaster Plan relevant to parents/guardians or the public; b) Procedures and instructions for what parents/ guardians can expect if something happens at the facility; c) Description of how parents/guardians will receive information and updates during or after a potential emergency or disaster situation; d) Situations that might require parents/guardians to have a contingency plan regarding how their children will					

be cared for in the unlikely event of a facility closure. Facilities should conduct an annual drill, test, or "practice use" of the communication options/mechanisms that are selected.					
STANDARD 9.2.4.5: Emergency and Evacuation Drills/Exercises Policy The facility should have a policy documenting that emergency drills/exercises should be regularly practiced for geographically appropriate natural disasters and human generated events such as: a) Fire, monthly; b) Tornadoes, on a monthly basis in tornado season; c) Floods, before the flood season; d) Earthquakes, every six months; e) Hurricanes, annually; f) Threatening person outside or inside the facility; g) Rabid animal; h) Toxic chemical spill; i) Nuclear event. All drills/exercises should be recorded. A fire evacuation procedure should be approved and certified in writing by a fire inspector for centers, and by a local fire department representative for large and small family child care homes, during an annual on-site visit when an evacuation drill is observed and the facility is inspected for fire safety hazards. Depending on the type of disaster, the emergency drill may be within the existing facility such as in the case of earthquakes or tornadoes where the drill might be moving to a certain location within the building (basements, away from windows, etc.) Evacuation drills/exercises should be practiced at various times of the day, including nap time, during varied activities and from all exits. Children should be accounted for during the practice. The facility should time evacuation procedures. They should aim to evacuate all persons in the specific number of minutes recommended by the local fire department for the fire evacuation, or recommended by emergency response personnel. Cribs designed to be used as evacuation cribs, can be used to evacuate infants, if rolling is possible on the evacuation	**290-2-3-.11 Health, Safety, and Discipline** (c) The home shall practice fire drill procedures with children at least monthly. Such drills shall be documented and maintained on file for one year.	Partially meets.	Rule states practicing fire drills but there are no details or procedures to be followed; nor are other emergencies covered.	Develop content from the Stepping Stones standard to cover the other emergencies listed and other procedures to be followed.	

route(s).					
STANDARD 9.4.1.10: Documentation of Parent/Guardian Notification of Injury, Illness, or Death in Program The facility should document that a child's parent/guardian was notified immediately in the event of a death of their child, of an injury or illness of their child that required professional medical attention, or if their child was lost/missing. Documentation should also occur noting when law enforcement was notified (immediately) in the event of a death of a child or a lost/missing child. The facility should document in accordance with state regulations, its response to any of the following events: a) Death; b) Serious injury or illness that required medical attention; c) Reportable infectious disease; d) Any other significant event relating to the health and safety of a child (such as a lost child, a fire or other structural damage, work stoppage, or closure of the facility). The caregiver/teacher should call 9-1-1 to insure immediate emergency medical support for a death or serious injury or illness. They should follow state regulations with regard to when they should notify state agencies such as the licensing agency and the local or state health department about any of the above events.	**290-2-3-.11 Health, Safety, and Discipline.** (c) Parent or guardian of any child who becomes ill or is injured while in care shall be notified immediately of any illness or injury requiring professional medical attention, or any illness which may not require professional medical attention but which produces symptoms causing moderate discomfort to the child, such as, but not limited to, any of the following: elevated temperature, vomiting or diarrhea.	Meets.			
STANDARD 9.4.1.12: Record of Valid License, Certificate, or Registration of Facility Every facility should hold a valid license or certificate, or documentation of, registration prior to operation as required by the local and/or state statute.	**290-2-3-.15 Enforcement and Penalties.** No family day care home shall operate in the State without a Certificate of Registration that has been issued by the Department. A registration to operate a family day care home may be denied, revoked, restricted or suspended in accordance with the following: (a) **Refusal of a License, Commission or Registration**. The Department shall refuse to	Meets.			

	issue a registration upon a showing of: 1. Noncompliance with the Rules and Regulations for Family Day Care Homes which are designated in writing to the facilities as being related to children's health and safety; or 2. Flagrant and continued operation of an unregistered family day care home in contravention of the law; or 3. Prior license, commission or registration denial or revocation within one (1) year of application. (b) **Refusal of a License, Commission or Registration**. The Department may refuse to issue a registration upon a showing of: 1. The applicant or the agent of the applicant denies the Department's representative access to the family day care home for the purposes of determining whether a registration will be granted; or 2. The owner or employees of the family day care home do not undergo the applicable records check and receive satisfactory determinations; or 3. The applicant or agent of the applicant knowingly makes any false statement of material information in connection with the application for registration, or in the alteration or falsification of records maintained by the applicant in connection with the application for registration; or 4. The applicant or alter ego of the applicant has transferred ownership or governing authority of a family day care home, group day care home or a child care learning center within one (1) year of the date of the new application when such transfer was made in order to avert denial, suspension, or revocation of a license, commission or registration; or 5. The applicant or alter ego of the applicant or persons in management or control of the family day care home have				

	failed to pay a civil penalty or enforcement fine previously imposed by the Department. (c) **Revocation of a License, Commission or Registration**. The Department may revoke a registration in the following instances: 1. Where the Department's representative is refused access to the family day care home for the purpose of determining whether the family day care home is in compliance with these rules; or 2. Where the Department determines that a non-correctable deficiency, abuse or dereliction exists in the operation or management of the family day care home; or 3. Where the Department determines that a correctable abuse, dereliction or deficiency in the operation or management of the family day care home has not been corrected within a reasonable time after: (i) having been brought immediately to the attention of the administrator of the family day care home by a Department representative; and (ii) having been advised in writing of the deficiencies and setting a time not to exceed ten (10) working days for the filing of an acceptable plan of correction; and (iii) the provider fails to submit an acceptable plan of correction to the Department within the specified time limits. In determining whether a plan of correction is acceptable, the Department will consider the extent of the deficiencies, whether the provider has previously been cited for the same deficiencies, the history of compliance including whether the provider has complied with previous plans of correction, and whether the				

	correction required can be maintained over time; or 4. The provider fails to follow the accepted plan of correction; or 5. Where the provider or the provider's employees do not undergo the applicable records checks and receive satisfactory determinations; or 6. Where there is a flagrant abuse, dereliction or deficiency that constitutes shocking intentional misconduct; or 7. Where the provider knowingly makes any false statement of material information in connection with any statement made or on any documents submitted to the Department as part of an inspection, survey, or investigation, or in the alteration or falsification of records maintained by the provider; or 8. Where the provider or alter ego of the provider fails to pay a civil penalty or enforcement fine imposed by the Department after the time period for requesting an appeal of the notice of imposition of civil penalty or enforcement fine has expired and the provider has not submitted an appeal within required time frame in accordance with these rules and regulations; or 9. Where the provider fails to pay a civil penalty or enforcement fine imposed by the Department after the licensee has submitted a timely appeal of the notice of imposition of civil penalty or enforcement fine and the imposition of the civil penalty or enforcement fine has been affirmed in accordance with the Georgia Administrative Procedure Act, O.C.G.A. Sec. 50-13-1 et seq., and applicable law. (d) **Suspension of a Registration**. The Department may suspend the registration to				

	operate a family day care home in the following instances: 1. Where the provider or employees of a family day care home do not undergo the applicable records checks and receive satisfactory determinations, or 2. Where the Department finds that the public health, safety or welfare imperatively requires emergency action and incorporates a finding to this effect in its order summarily suspending the license pending proceedings for revocation or other action, which proceedings shall be promptly instituted and determined. (e) **Restriction of a Registration**. The Department may restrict or limit a registration from providing certain kinds of care or services to children or limiting the number and/or age of the children who may be served if the Department determines that the provider either cannot comply with these rules or has not complied with these rules.				
STANDARD 9.4.2.6: Contents of Medication Record The file for each child should include a medication record maintained on an ongoing basis by designated staff for all prescription and non-prescription (over-the-counter [OTC]) medications. State requirements should be checked and followed. The medication record for prescription and non-prescription medications should include the following: a) A separate consent signed by the parent/guardian for each medication the caregiver/teacher has permission to administer to the child; each consent should include the child's name, medication, time, dose, how to give the medication, and start and end dates when it should be given; b) Authorization from the prescribing health professional for each prescription and non-prescription medication; this authorization should also include potential side effects and other warnings about the medication (exception: non-prescription sunscreen and insect repellent always	**290-2-3-.11 Health, Safety, and Discipline** Each dose of medication given to a child shall be documented showing the child's name, name of medication, date and time given, and the name of the person giving the medication. **290-2-3-.08 Children's Records.** (1) The home shall maintain current and updated individual records on each child in care. The home shall maintain the records outlined herein while the child is in care and for a period of one (1) year after such child is no longer in care at the family day care home. Such records shall include: (e) Documentation of any medications	Meets.			

require parental/guardian consent but do not require instructions from each child's individual medical provider); c) Administration log which includes the child's name, the medication that was given, the dose, the route of administration, the time and date, and the signature or initials of the person administering the medication. For medications given "as needed," record the reason the medication was given. Space should be available for notations of any side-effects noted after the medication was given or if the dose was not retained because of the child vomiting or spitting out the medication. Documentation should also be made of attempts to give medications that were refused by the child; d) Information about prescription medication brought to the facility by the parents/guardians in the original, labeled container with a label that includes the child's name, date filled, prescribing clinician's name, pharmacy name and phone number, dosage/ instructions, and relevant warnings. Potential side effects and other warnings about the medication should be listed on the authorization form; e) Non prescription medications should be brought to the facility in the original container, labeled with the child's complete name and administered according to the authorization completed by the person with prescriptive authority; f) For medications that are to be given or available to be given for the entire year, a Care Plan should also be in place (for instance, inhalers for asthma or epinephrine for possible allergy); g) Side effects.	given as described in rule .11 (1)(e); (c) The policies and procedures shall also include written procedures for the following: 3. Administering medication and recording noticeable adverse reactions to medication;				
STANDARD 10.4.2.1: Frequency of Inspections for Family Child Care Homes The licensing inspector should make an onsite inspection to measure compliance with licensing rules prior to issuing an initial license and at least two inspections each year to each center and large and small family child care home thereafter. At least one of the inspections should be unannounced and more if needed for the facility to achieve satisfactory compliance or is closed at any time (1). Sufficient numbers of licensing inspectors should be hired to provide adequate	**290-2-3-.04 Registration Requirements and Applications** (b) Pre-Registration Visit. Following receipt and review of the complete application package, the department may conduct an on-site inspection of the potential family day home to assess compliance with these rules. The department may deny the application for registration if conditions are found during the on-site inspection that pose health	Meets.			

time visiting and inspecting facilities to insure compliance with regulations The number of inspections should not include those inspections conducted for the purpose of investigating complaints. Complaints should be investigated promptly, based on severity of the complaint. States are encouraged to post the results of licensing inspections, including complaints, on the Internet for parent and public review. Parents/guardians should be provided easy access to the licensing rules and made aware of how to report complaints to the licensing agency.	and/or safety risks to children.				