BEFORE THE OFFICE OF STATE ADMINISTRATIVE HEARINGS
STATE OF GEORGIA

GENERATION KIDS PRESCHOOL NURSERY, INC.,	:	
Petitioner,	:	**Docket No.: OSAH-DECAL-CCLC-1512274-63-Baxter**
v.	:	
GEORGIA DEPARTMENT OF EARLY CARE AND LEARNING,	:	
Respondent.	:	

AMENDED[1] INITIAL DECISION

Petitioner appeals the Georgia Department of Early Care and Learning's (the "Department's") revocation of its license to operate a Child Care Learning Center. The administrative hearing was held on February 13, 2015. After consideration of the evidence and the arguments of the parties, and for the reasons stated below, the Department's decision to revoke Petitioner's license to operate a Child Care Learning Center is **REVERSED**.

I. FINDINGS OF FACT

1.

Petitioner operates a Child Care Learning Center at 2267 Pinewood Drive, Brunswick, Georgia ("Facility"). (Ex. R-8.)

2.

The tragic facts of this case are not really in dispute. On August 12, 2014, Lakesha Loadholt dropped her 14 week old son, K.A., off at Petitioner's Facility at approximately 7:10 a.m. She left her son in his car seat with the Facility's owner, Angela Odom. K.A. had been attending the Facility for two months and had a history of being fussy at the Facility. (Testimony of Loadholt, Odom, Dasher.)

3.

K.A. remained in his car seat until 8:00 a.m., when Patreka Dasher, the infant room caretaker, arrived at the Facility and took him to the infant room. When Dasher arrived, K.A. was

[1] Footnote 3 has been revised to correct a typographical error in the original order.

screaming. Dasher had five infants in her care at that time. The state maximum ratio is one caretaker to six infants. (Testimony of Odom, Dasher, Mitchell; Ex. R-1.)

4.

At 8:10 a.m., Dasher attempted to feed K.A. a bottle made up by his mother which was a combination of cereal and formula. Odom had left the bottle on a shelf instead of refrigerating it. The infant ate little and Dasher could not get him to burp. (Testimony of Dasher; Ex. R-1.)

5.

At approximately 8:38 a.m., Dasher placed K.A. in his crib on his stomach while he was crying.[2] Dasher proceeded to feed the other infants while attempting to soothe K.A. with talking. Dasher could see K.A. while she was feeding the other infants. (Testimony of Dasher; Ex. R-1.)

6.

Around 9:40 a.m., a parent dropped a sixth infant off in the room and Dasher fed that infant. Around that same time, Dasher noticed that K.A. had stopped crying.[3] At approximately 9:45 a.m., Dasher checked on each of the infants. Dasher wiped K.A.'s nose and washed her hands, but when he did not wake up, she returned and realized that he was unresponsive. Dasher called for assistance and Odom started CPR. Another employee called 911. K.A. was transported to the hospital where he was pronounced dead. (Testimony of Odom, Dasher; Exs. R-1, R-6, R-9.)

7.

Odom appropriately and promptly notified the Department about the incident. A Department Childcare Consultant, Kimberly Mitchell, conducted a site visit the following day. She took written statements and pictures of the infant room. Mitchell found the employees to be cooperative and not self-serving in their recollection of the incident. (Testimony of Mitchell; Exs. R-2, R-3, R-4, R-5, R-9.)

8.

In addition to interviewing Petitioner's employees, Mitchell also reviewed the police report and the Petitioner's compliance history. Petitioner had a "compliant" history meaning that the Department had identified very few issues of non-compliance in previous site visits. On average,

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[2] Dasher testified that she placed K.A. on his stomach at his mother's request. Loadholt testified that she did not tell Dasher that K.A. could be placed on his stomach. Whether or not the mother advised Dasher to place her infant on his stomach is not relevant for this proceeding. (Testimony of Loadholt, Dasher; Ex. R-9.)

[3] Dasher testified that her time was an estimate and that K.A. was quiet for approximately 5 to 10 minutes. (Testimony of Dasher.)

a Department site visit identifies 3.5 rule violations at facilities across the state. (Testimony of Mitchell, Rogers; Ex. R-8.)

9.

Of significance to this investigation was a February 2014 site visit in which the Department cited Petitioner for a Safe Sleep (Rule 30) violation for allowing a blanket and a washcloth to be placed in an infant's crib. As part of its Plan of Improvement for that site visit, Petitioner agreed to ensure that no objects were allowed in the cribs. In fact, Petitioner followed through on this commitment as Dasher prohibited Loadholt from placing a pillow in K.A.'s crib. (Testimony of Mitchell, Dasher; Ex. R-10.)

10.

As of the hearing date, the Department had not received any of K.A.'s medical records or the Georgia Bureau of Investigation's autopsy report. (Testimony of Mitchell.)

11.

As a result of this incident and the Department's investigation, the Department identified the following rules violations:

a) Petitioner violated Department Rule 30 (Safe Sleep) requiring infants to be placed on their back to sleep unless the center has been provided a physician's written statement authorizing another sleep position for that infant.
b) Petitioner violated Department Rule 32 (Supervision) requiring children to be supervised at all times. The caretaker must be alert and able to respond promptly to the needs and actions of the infants.
c) Petitioner violated Department Rule 3 (Activities) requiring personnel to provide individual attention to each child by responding promptly to the child's distress signals and need for comfort.
d) Petitioner violated Department Rule 3 (Activities) requiring children less than three years of age to not spend more than one-half hour of time consecutively in confining equipment, such as a car seat.
e) Petitioner violated Department Rule 15 (Food Services) requiring baby bottles to be refrigerated at 40 degrees Fahrenheit or less.

(Ex. R-6.)

12.

On August 13, 2014, the Department issued an Intended Order of Emergency Closure and Petitioner has not been in operation since that order. (Ex. R-7.)

13.

On August 24, 2014, Petitioner provided a Plan of Improvement to the Department. This Plan was developed with the help of a professional consultant. The Plan proposed, among many areas of improvement, eliminating the infant classroom and converting it into a two-year-old classroom. (Ex. P-2.)

14.

On September 8, 2014, the Department revoked Petitioner's license for noncompliance of the Department's Rules. The Department's decision was based on the fact that (a) Petitioner had five rule violations, (b) one previous rule violation related to safe sleep procedures, and (c) an infant died in Petitioner's care. The Department found that Petitioner's level of care was sub-par and does not believe that children will be safe at the Facility. In its revocation letter, the Department stated that because of the rule violations, Petitioner had "seriously affected the health and safety of children and demonstrated the intentional and reckless disregard for the physical and mental health and safety of children." The Department's investigator, however, testified that her investigation could not conclude that anything Petitioner's employees did that day caused or even contributed to K.A.'s death. (Testimony of Mitchell, Rogers; Ex. R-8.)

15.

In general, the Department does not revoke a facility's license for rule violations until there have been three repeat violations of the same rule. Here, Petitioner had two violations related to safe sleep. (Testimony of Rogers.)

II. CONCLUSIONS OF LAW

1.

The Department bears the burden of proof in this matter. Ga. Comp. R. & Regs. 616-1-2-.07. The standard of proof is a preponderance of evidence. Ga. Comp. R. & Regs. 616-1-2-.21.

2.

The Department has the authority to revoke Petitioner's license for any number of reasons including failure to comply with licensing requirements and failure to comply with any provisions of the law. O.C.G.A. §§ 20-1A-12(b)(3), -12(b)(5), and -12(c)(5). Here, Department alleges five violations of the Department's Rules.

3.

Petitioner admits that its personnel failed to comply with the Department's Rules for health and

safety on August 12, 2014, as follows:

(1) The Petitioner placed an infant on his stomach to sleep, in violation of Ga. Comp. R. & Regs. 591-1-1-.30(2)(a);

(2) The Petitioner left an infant in his car seat for approximately 55 minutes, in violation of Ga. Comp. R. & Regs. 591-1-1-.03(3)(b);

(3) The Petitioner failed to refrigerate an infant's bottle, in violation of Ga. Comp. R. & Regs. 591-1-1-.15(3).

4.

The Department also alleges two violations related to supervision. Specifically, the Department alleges that Petitioner failed to (a) provide "watchful oversight" and "timely attention to [an infant's] actions and needs" and (b) respond promptly to an infant's "distress signals and need for comfort." Ga. Comp. R. & Regs. 591-1-1-.32(6), 591-1-1-.03(3)(d)(1). The evidence demonstrates that Petitioner's employee, Dasher, violated these rules by allowing K.A. to cry for approximately one hour with little individual attention while she attended to the other five infants' needs. The evidence, however, does not show a callous disregard for the infant's needs, but rather a caretaker juggling the multiple needs of five (and ultimately six) infants in a short time period.[4]

5.

Once a violation has been established, the Department may revoke the license to operate a Child Care Learning Center. O.C.G.A. § 20-1A-12(c)(5). Here, the Department seeks to revoke Petitioner's license based on five rule violations. The Department identified these rule violations during its investigation regarding the death of an infant while in Petitioner's care. The Department, however, presented no evidence that these rule violations caused the infant's death or that anything Petitioner's employees did that day caused the infant's death. The Department requests this Court to revoke Petitioner's license based solely on the five rule violations even though Department's own internal policy is not to revoke a license until a facility has three repeat violations of the same rule. Further, even though the Department took into account the

[4] Of note, the Department's Rules provide that an appropriate ratio is 6-to-1, that all children under the age of six months must be held while feeding, and that children must receive breakfast or morning snack. Ga. Comp. R. & Regs. 591-1-1-.15(6)(a), (2)(a), 591-1-1-.32. Thus, one caretaker cannot provide prolonged and individualized attention to any one infant without potentially violating Department rules regarding the care of the other five infants.

infant's death when revoking the license, it does not provide this Court with any proof that Petitioner contributed to the death in anyway. Without any evidence presented regarding the cause of the death and holding the Department to its own policy regarding revocations, this Court finds that Petitioner's license should not be revoked. The Court is further persuaded to allow Petitioner to retain its license by the fact that Petitioner is willing to cease operating an infant room at its Facility.

III. DECISION

The Department's revocation of Petitioner's license to operate a Child Care Learning Center is hereby **REVERSED**.

SO ORDERED, this 23rd day of March, 2015.

AMANDA C. BAXTER
Administrative Law Judge