VIRGINIA DEPARTMENT OF SOCIAL SERVICES

IN THE MATTER OF
BETHEL TEMPLE CHURCH OF DELIVERANCE **FILE #: 1105194-209-09**
BTCOD LITTLE EAGLES DAY CARE
1317 EAST LITTLE CREEK ROAD
NORFOLK, VIRGINIA 23518

TO: MELVIN FUTRELL, PASTOR
TAMMY E. FUTRELL, ADMINISTRATOR
BETHEL TEMPLE CHURCH OF DELIVERANCE
1317 EAST LITTLE CREEK ROAD
NORFOLK, VIRGINIA 23518

NOTICE OF FAILURE TO MEET REQUIREMENTS FOR RELIGIOUS EXEMPTION

BASED ON FINDINGS MADE BY STAFF OF THE VIRGINIA DEPARTMENT OF SOCIAL SERVICES (VDSS), DIVISION OF LICENSING PROGRAMS, DURING A COMPLAINT INSPECTION AT BETHEL TEMPLE CHURCH OF DELIVERANCE, BTCOD LITTLE EAGLES DAY CARE, 1317 EAST LITTLE CREEK ROAD, NORFOLK, VIRGINIA, 23518, ON MAY 26, 2010, IT HAS BEEN DETERMINED THAT THE RELIGIOUS EXEMPT CHILD DAY CENTER IS IN VIOLATION OF § 63.2-1716 AND § 63.2-1724 OF THE CODE OF VIRGINIA, THEREBY PLACING THE HEALTH, SAFETY, AND WELFARE OF CHILDREN AT RISK.

YOU ARE HEREBY NOTIFIED, PURSUANT TO § 63.2-1716 (C) OF THE CODE OF VIRGINIA, OF THE INTENT OF VDSS TO REVOKE YOUR EXEMPTION TO OPERATE A RELIGIOUSLY EXEMPT CHILD DAY CENTER.

THE MATTERS OF FACT AND LAW WHICH FORM THE BASIS FOR VDSS'S INTENDED ACTION ARE DETAILED IN THE ATTACHED VIOLATION NOTICE AND INCORPORATED AS PART OF THIS NOTICE OF FAILURE TO MEET REQUIREMENTS FOR RELIGIOUS EXEMPTION. THE VIOLATIONS OF THE CODE SUBSECTIONS LISTED BELOW CONSTITUTE THE GREATEST CONCERN FOR THE HEALTH, SAFETY, AND WELFARE OF CHILDREN AND ARE THE PRIMARY BASIS FOR THE INTENDED ACTION:

1.	**Section 63.2-1716-B.2**	**Supervision of children**
2.	**Section 63.2-1716-A.3**	**Staff child ratios**
3.	**Section 63.2-1716-B.6**	**Open & obvious hazards**
4.	**Section 63.2 -1724**	**Background regulations**

A seven-week old infant died while in care at the facility on May 25, 2010. Preliminary results from the medical examiner indicated the child suffocated. The complaint investigation revealed that the child was left alone to nap with nine other infants in a dark room and that the 53 foot distance between the room where the infants were napping and the room where staff were located prevented staff from providing appropriate supervision. Staff interviews revealed that it was standard practice to place infants on their stomachs for napping. Although the parents of the deceased infant had requested he be laid down on his back, the child was placed on his stomach to nap. Photos taken by local government officials indicated that the sheet on the infant's crib mattress was not form-fitted to the mattress and was loose fitted. The Department's investigation further determined that out of a total of ten cribs observed five cribs had mattresses with loose-fitted sheets.

On the day of the infant's death, it was discovered that there were two staff responsible for ten infants and later that morning, one staff had to be responsible for ten infants when the second staff left for a doctor's appointment. Section 63.2-1716.B.2 of the Code of Virginia requires the ratio to be one staff for every four infants under twenty-four months of age.

The complaint investigation revealed on the day of the infant's death, the facility had a total of 18 children in care under the age of two years, including the ten infants in the infant room. The Certificate of Occupancy issued by the City of Norfolk limits the facility to nine children under two and one half years of age. It was also determined during the investigation that the majority of staff employed at the facility, including the two designated infant staff, lacked required background checks.

THE RIGHT TO AMEND AND EXPAND THE GROUNDS FOR THIS ACTION, AS SET FORTH ABOVE, IS EXPRESSLY RESERVED.

OPERATION OF A FACILITY THAT IS SUBJECT TO LICENSURE WITHOUT A LICENSE OR EXEMPTION LETTER ISSUED BY THE VIRGINIA DEPARTMENT OF SOCIAL SERVICES AND REQUIRED BY LAW MAY RESULT IN A FINE, IMPRISONMENT OR BOTH.

BY: Lynne A. Williams, Director
Division of Licensing Programs

DATE: 6/16/10

You have the right to appeal this decision pursuant to the Administrative Process Act, §2.2-4000 et seq. of the Code of Virginia. Written notice of appeal must be received at the address below within 15 days of your signature on the return receipt of this letter. If you fail to appeal within the time period allowed, this letter will constitute VDSS's final decision, and 30 days after the receipt of this letter, the decision will take effect.

If you do appeal this decision, the process is as follows: Once the timely notice of appeal is received, an Informal Conference will be scheduled. You will be notified by VDSS of the date, time and place of the conference. The Informal Conference is your opportunity to present any evidence that may be considered by VDSS in making its case decision. After the Informal Conference, VDSS will issue a decision letter.

If you decide to appeal this decision, your notice of appeal must be in writing to the following person:

Ms. Beverly Kirby
Hearings Coordinator
Division of Licensing Programs
Virginia Department of Social Services
801 E. Main Street, 9th Floor
Richmond, Virginia 23219-2901
Telephone: (804) 726-7143

In the event of an appeal, the agency action will not take effect until the issuance of a Final Order.

LAW/SCH/amg

Attachment

cc: Kim Piner, Senior Assistant Attorney General
Allen Wilson, Senior Assistant Attorney General
Steve Lambert, Associate Director, Sr., Division of Licensing Programs
R. Brent Kennedy, Associate Director, Sr., Division of Licensing Programs
Susan C. Hackney, Licensing Administrator, Eastern Licensing Office
Jackie Ware, Licensing Inspector, Eastern Licensing Office
Rene Smith-Old, Licensing Inspector, Eastern Licensing Office

VIRGINIA DEPARTMENT OF SOCIAL SERVICES DIVISION OF LICENSING PROGRAMS

VIOLATION NOTICE

Facility Name Bethel Temple Church of Deliverance **Inspection Date** 05/26/10

Facility Number 1105194 **Findings Review Date** 05/26/10

Inspect. Type: Initial Renewal Monitoring **Complaint** Train/Consult Other Announced **Unannounced**

STANDARD NUMBER	DESCRIPTION OF VIOLATION	DESCRIPTION OF ACTION TO BE TAKEN (Preventative actions & Staff Responsibilities)	DATE TO BE CORRECTED
63.2-1716-B-2 (Complaint Related)	The center failed to establish and implement procedures for appropriate supervision of all children in care. Interviews with center director, center staff, and the victim child's mother revealed the following: Ten (10) infants, under the age of 12 months, were sleeping in a dark room, illuminated only by a small television on a shelf approximately five and a half feet off the ground, with music playing and a fan running. The infant area was not a part of the main childcare area. It was in a small room located across the sanctuary. The children had all been asleep since approximately 12:00 p.m. There was one staff member responsible for these children. She was eating lunch and talking with other staff in an area two rooms (approximately 53 feet) away from the infants thereby she was unable to provide appropriate supervision. She stated that she checked on the children every 15 to 30 minutes, but only by scanning the room from the door to ensure that all were still asleep; not by checking each individual infant. The victim child (who was the youngest child in care) was in a crib at the back of the room where he could not be easily seen by staff. The victim child had been put		

It is agreed that these violations will be corrected by the dates shown and that compliance will be maintained with all regulations.

If the facility representative wants further discussion of the findings, a conference with the licensing inspector and his or her supervisor may be requested. Please contact your licensing office within fifteen days of the findings review date.

Inspector Signature **Facility/Program Representative Signature**

Date **Date of Receipt** **Completion**

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	down to sleep on his stomach. At approximately 2:15 p.m., at the request of the Assistant Director, the staff member went in to get the victim child and found him in his crib clammy, lifeless and with a bluish hue. Paramedics later pronounced the child dead at the scene. During an interview with the victim child's mother she stated to local agency officials and Department representatives that she had instructed both the Director and the Assistant Director to place him on his back to sleep during the intake interview. Additionally, the mother stated that on the child's first day at the center, the child's father had reminded the infant room staff of this. Center staff informed Department representatives of the following practices of supervision: (a) staff being allowed to occasionally sleep in the infant room while on duty and the children were sleeping and (b) staff routinely leaving the room to wash and prepare bottles in the kitchen leaving only one staff member with over four (4) infants. COMPLAINT - VALID		

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63.2-1716-A	During the complaint investigation, an interview with the victim child's mother, interview with center staff, and paperwork provided by the center revealed that the facility failed to disclose in writing to the parent of the victim child that the center is exempt from licensure and failed to disclose the qualifications of the personnel employed therein. COMPLAINT - NOT REPORTED - VALID		

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63.2-1716-A-3	The required ratios for child under 24 months old in religiously exempt facilities is one staff for every four children. This ratio may never change when children this age are in care. Interviews with Facility Management and staff indicated that on 5/25/10 there were ten (10) infants present with two staff until 11:30 a.m. when one staff member left for a doctor's appointment. There were then ten (10) infants present with one staff member. Normal procedures, as stated by the staff, indicated that there was only one adult responsible for these children daily from 12:00-2:00 p.m. while the staff took turns going to lunch. COMPLAINT - NOT REPORTED - VALID		

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63.2-1716-A-6	During the complaint investigation, an interview with the victim child's mother, interview with center staff, and paperwork provided by the center revealed that the facility failed to disclose in writing to the victim child's mother information about physical facilities, enrollment capacity, food services, health requirements for the staff and public liability insurance. COMPLAINT - NOT REPORTED - VALID		

It is agreed that these violations will be corrected by the dates shown and that compliance will be maintained with all regulations.

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63.2-1716-B-4	The center failed to establish and implement procedures for ensuring that a person trained and certified in first aid is present at the center whenever children are present. On 5/26/10, interviews with the facility director and staff members revealed that prior to 9:00 a.m. on 5/25/2010, the day of the incident, there were no staff on duty who held a current certification in first aid. There were only two employees with current first aid training. Children arrived for care at the facility at 6:00 a.m. that morning. Additionally, a review of staff records revealed that only two of the twelve records contained documentation of completion of first aid training. COMPLAINT - NOT REPORTED - VALID		

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63.2-1716-B-5	The center failed to establish and implement procedures for ensuring that all children in the center are in compliance with the provisions of § 32.1-46 regarding the immunization of children against certain diseases. Department representatives reviewed 81 children's records during the investigation on 5/26/10 and discovered that 44 had either no immunizations or incomplete immunizations on file. Local officials stated that the victim child did not have immunizations on file. COMPLAINT - NOT REPORTED - VALID		

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63.2-1716-B-6	The center failed to establish and implement procedures to ensure that all areas of the premises accessible to children are free of open and obvious injury hazards as evidenced by: - The Certificate of Occupancy issued by City of Norfolk states that only nine (9) children under 2 1/2 may be in care at any one time. Additionally, this stipulation was in the exemption letter issued by the Department on 7/29/09. On the day of the incident there were 18 identified children under the age of two in care. Facility management stated that she was unaware of this stipulation. - Interviews with staff and a demonstration of the infant room environment by staff revealed infants were sleeping unattended in cribs in a room lit only by a small television, thereby preventing appropriate supervision. - Department representatives' observations of the infant room's furnishings revealed that five out of ten cribs had sheets that were too large to be tight fitting, therefore posing a suffocation hazard. Additionally, photos taken by local government officials indicated that the sheet on the victim child's bed was also very loose fitting.		

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	- Department representatives' observations of the infant room revealed an unlocked closet in the room that contained all the electrical boxes for the facility. The closet had double doors with no locking mechanism. Inside the closet there were wires extending from the four electrical circuit panels down to a reachable height for ambulating or crawling infants. This condition posed a possible entanglement/strangulation hazard. - Department representatives' observations of the infant room revealed unlocked Glade air freshener, Lysol, baby lotion, baby powder and anti-bacterial hand soap located on the bottom shelves of diaper changing table in the designated infant room. These shelves were approximately two to six inches off the floor and would have been readily accessible to children crawling and playing on the floor. COMPLAINT - NOT REPORTED - VALID		

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63.2-1724	Twelve staff records were reviewed and were missing the following elements of background checks: - Staff #1 - no Criminal Record Check (staff has been employed since center began operation in 8/08 and has signed Statement of Intent and Statement of Code Compliance) - Staff #2 - no Sworn Disclosure Statement, no Criminal Record Check - Staff #3 - no Sworn Disclosure Statement, no Criminal Record Check (has signed Statement of Intent and Statement of Code Compliance since facility opened) - Staff #4 - no Criminal Record Check (staff was listed on staff-child ratio information sheet submitted in 7/09) - Staff #5 - no Sworn Disclosure Statement, no Criminal Record Check (staff was listed on staff-child ratio information sheet submitted in 7/09) - Staff #6 - no Criminal Record Check (staff was listed on staff-child ratio information sheet submitted in 7/09) - Staff #7 - no Criminal Record Check (staff has been employed since center began operation in 8/08) - Staff #8 - no Criminal Record Check (staff has been employed since center began operation in 8/08)		

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	- Staff #9 - no Criminal Record Check (staff has been employed since center began operation in 8/08) - Staff #10 - no Sworn Disclosure Statement, no CPS Central Registry Check, no Criminal Record Check (staff member stated during interview that she began employment in 3/10) - Staff #11 - no CPS Central Registry Check, no Criminal Record Check (staff was listed on staff-child ratio information sheet submitted in 7/09) - Staff #12 - no Criminal Record Check Staff #10 and #11 were the staff responsible for caring for the ten infants including the victim child on the day of the incident. COMPLAINT - NOT REPORTED - VALID		

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