Guide to Child Care

Licensing Rules and Resources for Licensed Programs

Effective August 2026

South Dakota Department of Social Services

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Definitions

ARSD 67:42:17:01

A. Terms used in this chapter mean:

1. “Center program,” a day care center, as referenced in South Dakota Codified Law (SDCL) subdivision 26-6-14(3), and a group family day care home, as referenced in SDCL subdivision 26-6-14(5);
2. “Director,” the representative of the agency or organization responsible for the center or school-age program;
3. “Household member,” a person residing in a home or a home operated as a facility, used for the purpose of providing care and supervision to children, who may have contact with any children in the facility;
4. “Medication,” a prescription or over-the-counter substance that is intended to relieve pain or treat an illness or a disease;
5. “Parent,” a child's natural parent, adoptive parent, stepparent, or legal guardian;
6. “Program employee,” an individual who does not provide direct care to and supervision of a child;
7. “Provider,” an individual providing direct care to and supervision of a child; and
8. “School-age program,” a program providing for the care and supervision of children as defined in SDCL subdivision 26-6-14(6).

Licensing processes

ARSD 67:42:17:02 – 06; ARSD 67:42:17:50

A. Before submitting to the department an application for licensure, a center or school-age program shall submit to the department a copy of a building, renovation, or alteration plan, and obtain the department's approval of the plan.

B. The department shall, within sixty days after receiving a completed application, provide to the applicant written notice of the department's approval or denial of licensure or registration.

C. If the department denies the licensure or registration, the department shall provide the reason for the denial. An applicant may reapply after taking corrective action related to each reason listed in the denial.

D. The department shall conduct at least one pre-licensure inspection, and one unannounced inspection annually, to determine compliance with the licensing requirements.

E. If the inspection results in a plan of correction, the department shall provide a copy of the plan to any individual upon request.

F. A provider shall prominently display the department’s licensing telephone number and website in the licensed facility.

G. The department may revoke a license or registration certificate, due to non-compliance with a licensing or registration standard, by providing a thirty-day written notice to the provider.

H. The thirty-day written notice is not required if the department determines that the revocation is necessary to protect the health, safety, or welfare of a child.

I. The provider may not reapply for a license or registration certificate for one year after the date of revocation.

J. A provider shall, within twenty-four hours, report to the department:

1. A change of address;
2. Any major change in the operation or ownership of the program;
3. A change in the household size or composition;
4. Damage to or a change in the condition of the facility;

5. An investigation of the provider or a program employee, by the Division of Child Protection Services or law enforcement, concerning any allegation of:
   a. Child abuse or neglect; or
   b. Any action that may prohibit the provider or employee from meeting background check eligibility requirements;
6. Any injury to a child that requires medical attention or dental care; and
7. The death of a child, if related to a serious injury that occurred on the premises of the child care program.

K. A provider may request a fair hearing if the provider is dissatisfied with any action taken on an application or license or registration certificate. A fair hearing must be conducted under chapter 67:17:02.

Intent

Providers have the right to know and understand licensing processes so that they can successfully navigate and meet the expectations of the department. The initial licensing application process provides an opportunity for the department to identify any concerns or non-compliances and for the provider to correct them.

Inspections are the vehicle used to observe and document compliance with the requirements, clarify how compliance will be assessed, and provide technical assistance and resources. Posting the department's licensing telephone number and website assures parents that the facility is monitored and allows them to ask questions or voice concerns.

Denials or revocations of a license may be necessary when a provider is unable or unwilling to meet requirements, thereby putting children's health and safety at risk. It is important for licensing to be informed of incidents or changes in circumstances that affect a program's operation or require further review. Fair hearings offer providers the opportunity to present their concerns if they are dissatisfied with any licensing action taken.

Clarification

Before issuing a license, the department needs to complete a review of all materials, conduct a monitoring visit, and verify compliance with requirements. The department's decision to approve or deny the application must occur within 60 days; however, the timeframe of 60 days begins only after the provider has submitted a completed application with all necessary documentation.

By designating space, which is outlined on the license certificate exclusively for the child care or school age program, the safety and well-being of the children are prioritized. Ensuring that only enrolled children, their guardians, and authorized personnel have access during operational hours helps create a safe environment. This approach minimizes the risk of unauthorized access and potential disruptions, thereby supporting a stable and secure setting for child and school age care.

If planning to make building renovations, including adding or removing walls, current floor plans need to be submitted to the Office of Licensing and Accreditation for approval before renovations begin. Approval is required to ensure changes to a facility will not impact exiting requirements and to provide a determination for updated room capacities.

Licensed providers will have two annual inspections. The Office of Licensing and Accreditation (OLA) completes the annual program inspection, and the Department of Public Safety (DPS) completes the annual facility safety inspection. However, visits may be made more frequently to verify compliance with plans of correction, to investigate complaints, to respond to a self-reported incident by the provider, or to provide support or consultation.

Providers are notified of all non-compliance citations using a compliance plan, Corrective Action Plan or Stipulation Consent Agreement. All plans outline a timeframe for correction and are based on the degree of potential risk to children and amount of time needed to make the correction. All citations can be disputed within five working days of a provider receiving the compliance plan, Corrective Action Plan, or Stipulated Consent Agreement. Disputed citations can be directed to the Child Care Licensing Supervisor for consideration. A determination regarding the dispute will be made within five working days. After five working days, all plans of correction will be published for public viewing unless under review by OLA.

Providers must display the department's licensing telephone number and website in the program. Posting the updated license will meet this requirement as it includes the Department of Social Services (DSS) licensing telephone number and website.

To comply with federal requirements, providers need to report to the department any injury to a child that requires medical attention or dental care. If a child sees a physician or a dentist for evaluation of an injury, but no treatment is given, the injury does not meet the definition of serious and does not need to be reported. Examples of injuries that do not need to be reported include things like cuts or scrapes for which a child sees a physician, but no treatment is needed, a bump to a tooth if the dentist determines no treatment is needed, etc. Reporting the incident to the department also provides the opportunity to determine if anything can be done to reduce the risk of a reoccurrence. Providers must also report the death of a child that occurred on the premises of the child care program. The Serious Incident Reporting Form can be found at the link below in the Resources and Forms section.

In accordance with 67:17:02, providers or their representative must submit, within 30 days of the department's notice of an intended action such as a denial or revocation, a written and signed request for a fair hearing to the Department of Social Services, Office of Administrative Hearings.

Indicators

- ☑ Observe that the department's licensing telephone number and website are prominently displayed.
- ☑ Verify that incidents or changes in circumstances that affect a program's operation have been reported to the department within 24 hours of their occurrence.

Resources and Forms

The department's licensing website includes information on licensing and registration and background screening, and other resources at https://dss.sd.gov/childcare/licensing/.

Floor Plan Review Process and Program Proposal booklets for programs in school buildings and for those not located in school buildings are available on the DSS website at https://dss.sd.gov/formsandpubs/.

A Serious Incident Reporting Form to document a child's serious injury or death is available on the DSS website at https://dss.sd.gov/formsandpubs/.

Provider requirements

ARSD 67:42:17:13 & 14

A. All child care providers, program employees age fourteen and older, and household members age eighteen and older shall meet federal background check requirements. An individual may not provide care, live, or work in a child care setting if the individual's background check reveals:

1. A crime that indicates harmful behavior toward children;
2. A crime of violence, as defined by SDCL 22-1-2 or in a similar statute from another state;
3. A sex crime pursuant to SDCL chapters 22-22 or 22-24A, SDCL 22-22A-3, or similar statutes from another state;
4. A felony conviction for domestic abuse, physical assault, battery, kidnapping, or arson;
5. Any other felony conviction, within the preceding five years; or
6. A substantiated report of child abuse or neglect.

B. A background check is required at least once every five years.

C. Upon completion of a background check, the department must notify the program of an individual's eligibility or ineligibility for employment.

D. If the individual is ineligible for employment, the department must include guidance regarding the appeal process.

Intent

In order to provide a safe and secure environment for the children enrolled in the child care program, all reasonable measures must be taken to protect children from the risk of abuse, harm, or neglect. Children and providers can be protected from potentially dangerous employees when people with certain criminal convictions and confirmed child abuse or neglect are prohibited from working in a child care program. The federal Child Care and Development Block Grant, reauthorized in 2014, requires comprehensive background checks for all child care providers caring for unrelated children and for all providers receiving federal subsidies. Requiring a check of criminal records, the Central

Registry of Child Abuse and Neglect, and the sex offender registry provide additional protection against individuals avoiding detection by using other names or files not being forwarded to the applicable agencies.

Clarification

A provider or other program employee must submit a request for a background check to the department and receive the background screening eligibility results prior to being employed. Background checks are required for all providers and program employees hired to work in a licensed program including directors, providers who provide care and supervision of children, and persons in the facility having unsupervised access to children in care including volunteers.

A person is ineligible to work in a program if they:

1. do not have a cleared background screening;
2. refuse to consent to a background check;
3. knowingly make false statements in connection with the background check; or
4. are registered or required to be registered on a state sex offender registry.

The department's website provides information on required background checks, prohibited offenses, and out-of-state checks for each state that a provider or program employee has resided in during the preceding five years: https://dss.sd.gov/childcare/background_screening.aspx.

State law prohibits any individual whose name appears on the Central Registry of Child Abuse and Neglect from residing or working in a licensed child care program. A person whose name appears on the Central Registry has certain due process rights that need to be adhered to by the department.

Background checks can only be requested from the department on individuals employed at or volunteering or residing in a licensed program.

Prior to employment and working with children, all providers must complete and receive the results of a comprehensive background check including the Federal Bureau of Investigation (FBI), the Division of Criminal Investigation (DCI), Central Registry, Sex Offender Registry, and the National Crime Information Center (NCIC).

Child care and school-age programs must determine if each employee has lived outside of South Dakota in the past five years. If yes, an out-of-state screening must be completed for each state where the individual resided within the past five years, if the employee lived out of state as an adult (18 years of older). The child care or school-age care program must retain a listing of states in which the employee has lived with corresponding dates for a period of five years prior to employment. One method to meet this requirement is to maintain a copy of the Permission to Screen for Child Abuse and Neglect form for each employee prior to submitting the form to the department for screening. Another option is to maintain a listing in an employee's file that shows all states lived in and dates for the previous five years.

If a new provider or program employee completed a background check with another licensed provider within the past five years, and there has been a lapse of no more than 180 days between employment with a child care program, the provider can request a copy of the background screening eligibility notification when submiting a background check request via the Provider Portal.

Even though the previous background check is acceptable for employment, if it meets these conditions, a program may request a new background check to ensure there are not changes with the provider's background.

To begin, the necessary Steps to complete the on-line process are outlined below:

Step 1: Complete your fingerprinting process. Do this before you proceed to complete the on-line request in the Provider Portal. There are two options for capturing fingerprints below. The digital live scan print option is the preferred method to expedite results.

Digital Live Scan Prints - Follow the instruction on the DSS Child Care website: Live Scan Instructions and Locations

Ink-rolled Prints - Complete your prints using cards provided by the Office of Licensing & Accreditation. Cards can be obtained through your local licensing specialist if needed. Ensure all fields on the cards are completed prior to submission. Incomplete cards will be returned before processing.

Step 2: Complete out of state forms.

This step is not required for individuals less than 18 years of age or adults who have lived in South Dakota for the past five years.

For individuals who are 18 years or older and lived outside of South Dakota in the past five years as an adult, an out of state criminal record and central registry screening is required. Forms for each state are located on the DSS website. Please complete the required forms (link provided below) for each state lived in the past 5 years and mail to:

Office of Licensing and Accreditation
700 Governor's Drive
Pierre, SD 57501

Ensure you follow the specific instructions outlined on each form. Incomplete forms will be returned before processing.

The SD Child Care Licensing Office will complete the out-of-state sex offender registry check.

Step 3: Complete the on-line Background Check request in the provider portal.

Complete the information requested in the provider portal. The required Declaration of Prior Criminal Convictions/Military History and Permission to Screen forms for each individual screened will be available to download, complete, and upload into the system.

If submitting ink-rolled fingerprint cards, you will need to print the request form completed in the portal and mail with your cards to:

Office of Licensing & Accreditation
700 Governor's Drive
Pierre, SD 57501

Once all required information is completed and uploaded, you will submit the request. Results will be returned to you via the Provider Portal. If a provider or program employee is determined to be ineligible for employment, a separate letter will be sent to the individual with additional information for the appeal process.

It is the program's responsibility to complete the comprehensive background check process for all providers and program employees at least once every five years

Indicators

- ☑ Review all employee records including the background check eligibility letter from OLA.
- ☑ Ensure both in-state and out-of-state eligibility letters are on file if applicable.
- ☑ Review files to ensure that a comprehensive background check is completed at least once every five years as applicable.

Resources and Forms

The department's website describes required background checks, prohibited offenses, and out-of-state checks at https://dss.sd.gov/childcare/background_screening.aspx.

Permission to Screen for Reports of Abuse or Neglect form is available on the DSS website at https://dss.sd.gov/formsandpubs/.

Child Care Declaration of Prior Criminal Conviction and Military History form is available on the DSS website at https://dss.sd.gov/formsandpubs/.

ARSD 67:42:17:07 – 67:42:17:11

E. The owner and director are responsible for the day-to-day operation of the program, including the supervision of staff and compliance with all licensing standards.

F. The owner of a licensed child care or school-age program may be an agency, institution, organization, or a natural person who is at least 18 years of age.

G. The program administrator is the director or individual responsible for planning and implementing the program in a licensed child care or school-age program and must be at least eighteen years of age and:

1. Have a bachelor's degree in a field of education or human development;
2. Have a two-year degree in early childhood education;
3. Have a Child Development Associate (CDA) credential or comparable credential, as determined by the department;
4. Hold certification in a specific child learning philosophy and have at least one year of experience in a child care setting;
5. Have a child development technician diploma; or
6. Have four years of experience in a center or school age program.

H. All providers shall be at least eighteen years of age and demonstrate and maintain the ability to provide care that attends to the child's physical growth and development and to the physical, emotional, cognitive, and social needs of the child, as determined by the department.

I. In a licensed child care or school-age program, a provider's assistant must be at least fourteen years old, may not be left alone with children in care, and may be counted in the staff-child ratio only when the assistant is under the direct supervision of a provider, a program director, or the individual responsible for planning and implementing the program. A provider's assistant shall demonstrate the ability to provide care that attends to the child's physical growth and development and to the physical, emotional, cognitive, and social needs of the child.

Intent

The well-being of the children, confidence of the parents, and professional growth of the providers depend upon the presence, knowledge, skills, abilities, and dependability of the director or the person responsible for planning and implementing the program. That person plays a crucial role in ensuring the smooth day-to-day operation of the program by balancing business concerns with what's good for children and families and by providing leadership and direction to the providers. Both administrative and child development skills are essential for them to manage the program and set appropriate expectations for parents and providers.

Child and school-age care is a physically and emotionally demanding profession which requires an understanding of children and their needs. Each child depends on their provider for continuous affection, physical care, intellectual guidance, and emotional support, which can be very taxing on a daily basis. Providers must be at least 18 years of age as they must have the maturity to plan daily activities, act to keep children safe, make independent decisions, and respond appropriately to the needs of children.

Clarification

For centers and school-age programs, the owner or board of directors designates the person who acts as the director or the person responsible for planning and implementing the program who meets qualifications for the position. Licensing should be notified of any changes in this position so that the educational requirements can be verified.

Programs are set up in a variety of ways and may have different names for different positions. There may be a lead teacher, a teacher, and an assistant teacher in one classroom. Because of these variances among regulated programs, the terms provider and provider assistant are used in the Administrative Rules of South Dakota (ARSD) and this document.

Documentation that the program administrator meets the qualifications for the position must be provided to licensing, e.g., a degree, diploma, or certificate or documentation of experience. If a person seeking to serve as the program administrator has a credential or certification other than those listed, they should seek guidance and approval from licensing. Experience includes employment in a child care or school-age program but does not include care such as in-home family day care, Sunday school, scouting, and babysitting. Experience may be documented with statements from prior employers.

The program administrator must be on site for a sufficient number of the program's operating hours to provide oversight including employee supervision, compliance with licensing requirements, communication with parents, etc. If concerns exist, the licensing specialist may request a written plan for how program oversight is provided.

The program administrator should be intentional in ensuring that each provider has the support and resources they need to successfully meet children's needs. Examples of ways to support providers are reflective supervision or mentoring, training during staff meetings, access to training videos, development of lesson plans, and a written policy on curriculum development that can also be shared with parents.

Provider requirements including age, training, and background check must be met by anyone that provides care, is counted in the ratio, or is alone with children. Individuals who do not provide care or are not alone with children, such as volunteers and bus drivers, do not need to meet the provider requirements if there is another program employee present with children.

A provider's assistant under 18 years of age may not be left alone with children in care.

Substitutes must complete background check requirements and orientation training.

Providers need to be physically and emotionally healthy to perform the tasks of providing care to children. When it is reported or observed that a provider may have a physical, mental, or emotional condition that could impact their ability to provide care, a licensed health practitioner's statement may be requested.

If a provider is found to be unable to perform the activities required for the job because of health limitations, a change in their duties, reasonable accommodations, or termination should be considered until the health condition resolves. Under the Americans with Disabilities Act (ADA), employers are expected to make reasonable accommodations for persons with disabilities based on an individual case-by-case situation. Directors must ensure the competent functioning of providers and the well-being of children in care.

Indicators

- ☑ Review personnel records to verify that providers meet the standards for minimum age.
- ☑ Verify that the director or person responsible for planning and implementing the program meets the minimum qualifications.
- ☑ Discuss with the director or individual responsible for planning and implementing the program how they ensure that all providers are able to support each child's physical, emotional, cognitive, and social needs.
- ☑ Observe providers' interactions with children, management of the classroom and activities, appropriate supervision, etc., to verify their ability to meet the physical, emotional, cognitive, and social needs of the child.

Resources and Forms

For more information on the Child Development Associate Project and the South Dakota Out-of-School Time (OST) Credential training program, see Child Development Associate Project (sd.gov).

South Dakota Pathways to Professional Development is a statewide project recognizing those who work in child care with entry-level education or advanced degrees. Learn more at https://sdece.org/pathways/.

A sample staff information form is available on the DSS website at https://dss.sd.gov/formsandpubs/.

South Dakota ECE Resources hub offers information to support child care and school-age care providers in their business and classrooms - SDeceResources.org.

Resources for Board of Directors:

https://boardsource.org/

https://www.councilofnonprofits.org/tools-resources/board-roles-and-responsibilities

https://www.gsa.gov/system/files/Board_of_Directors_Resource_Book_2016.pdf

ARSD 67:42:17:15

J. A child care provider shall maintain a record for each employee that includes:

1. The employee's name and date of birth;
2. The dates on which the employee began and ended employment;
3. Documentation of orientation and ongoing annual training, if the employee provides direct care and supervision of children;
4. A statement that:
   a. Defines child abuse and neglect;
   b. Sets forth the employee's responsibility to report all incidents of child abuse or neglect in accordance with SDCL 26-8A-3 and 26-8A-8; and
   c. Is signed by the employee.
5. The results of the background check.

K. All required provider records shall be:

1. Reviewed and updated at least annually;
2. Made available to the department for verification of the contents; and
3. Retained for six months after the staff member leaves the program.

Intent

Up-to-date employee records are an essential tool in safeguarding children and providers in a child care setting. They are important for directors to know who they are hiring to work with children and to demonstrate compliance with licensing standards. Asking providers to sign a statement regarding their reporting responsibilities for child abuse and neglect confirms that they are aware of this critical role.

Provider records are kept for six months after the person leaves the program in case questions arise.

Clarification

Information that should be updated annually includes provider contact information, annual training records, current pediatric CPR certification, Level II health and safety training, and background checks within the last five years. In addition to forms required by licensing, employers may implement additional procedures that go beyond these requirements to assist in hiring quality providers. Information collected to complete the employee records process is to remain on site and available for review by the department.

Orientation and training records should include the topic, date, and hours of the training. Original certificates are required to verify an employee has met the training requirements.

While reference checks are not required, child care programs are strongly encouraged to complete them as part of the hiring process to help determine whether an applicant is a good fit for the position. Contacting previous employers—particularly those in child care settings—can provide valuable insight into an applicant's experience, reliability, interactions with children, and ability to follow policies and procedures, even if those employers were not listed as references. Conducting reference checks supports informed hiring decisions, helps promote a safe and nurturing environment for children, and may reduce the risk of hiring individuals who are not well-suited for working in a regulated child care setting.

Indicators

- ☑ Review files of all new employees that were not previously reviewed to verify that they include the required information.
- ☑ For programs with up to 10 employees, review all employee training records.
- ☑ For programs with 11 or more employees, review a minimum of 10 employee training records or 20% of all employee training records, whichever is greater.
- ☑ View the statements signed by each employee to verify that they include both the definition of abuse and neglect and providers' reporting responsibilities.
- ☑ Ask how often records are reviewed/updated.
- ☑ Ask to see employee records for providers who are no longer with the program.

Resources and Forms

Caring for Our Children (CFOC) 4th ed. Standard 9.4.3.1 Maintenance and Content of Staff and Volunteer Records, p. 424, lists items that could be included in provider records at CFOC4 pdf- FINAL.pdf (nrckids.org).

A sample Child Care Provider Training Record is available on the DSS website at https://dss.sd.gov/formsandpubs/.

Acknowledgement of Responsibility to Report Suspected Child Abuse and Neglect is available on the DSS website at https://dss.sd.gov/formsandpubs/.

Caring for Our Children Basics (CFOCB) outlines a set of voluntary, foundational health and safety standards for early care and education programs. https://childcareta.acf.hhs.gov/cfoc

ARSD 67:42:17:16

L. The files and records of a provider are confidential. A child's records, photographs, and information about a child or the child's family may not be shared or publicly posted, unless the parent signs a consent form. Nothing in this section prevents licensing specialists, child protective services, or law enforcement from accessing the files and records of a provider or family information.

Intent

Providers can best meet children's needs if information is shared freely by parents.

Confidentiality is essential for parents to feel confident that the information they share with providers about their child and family situation will not be shared with others. Requiring signed authorization for sharing information with unauthorized individuals protects the parents' and the child's right to privacy.

Clarification

Sharing of confidential information should be selective and should be on a need-to-know basis and on the parents' authorization for disclosure of such information. Providers should know that sharing family information in conversation, on social media, in email, etc., with any person *who does not have a work-related need to know the information* is a breach of confidentiality. Sharing pictures of children in care on social media, in email, etc. is not acceptable without prior parental permission. Even seemingly harmless posts on social media sites can violate the privacy of children and families and could make families uncomfortable.

To maintain confidentiality, it is recommended that only a limited number of providers have access to sensitive information about the children enrolled while still allowing access to pertinent information such as emergency contact numbers, allergies, and persons authorized to pick up the child.

Providers should not engage in activities that share images or information about children in care with others, including on social media platforms, unless parents provide consent.

Indicators

- ☑ Ask how the program ensures confidentiality with children's information, e.g., written policies and procedures, provider training.
- ☑ Observe areas within the program such as classrooms, offices, and dining areas to ensure that children's confidential information is viewable only to persons who have a "need to know" or there is a signed authorization by parents.

Resources and Forms

CFOC 4th ed. Standard 9.4.1.3 Written Policy on Confidentiality of Records, p. 409, reviews procedures to be put in place to address confidentiality of children's records at CFOC4 pdf- FINAL.pdf (nrckids.org).

The Family Child Care Association of Maine provides tips on common situations and policies regarding confidentiality applicable to all child care settings at https://fccamaine.com/2019/02/01/confidentiality/.

More information relating to ADA requirements can be found at https://www.ada.gov/.

This four-minute video regarding confidentiality provides a director's perspective and gives examples of how to respond when asked to share confidential information. https://www.youtube.com/watch?v=MXV7sd-n-Yk .

Pre-service and ongoing professional development

ARSD 67:42:17:17 and 67:42:17:18

A. All providers shall, within ninety days after the date of employment, complete and obtain documentation of orientation in the following areas:

1. Prevention and control of infectious diseases;
2. Prevention of sudden infant death syndrome and use of safe sleep practices if infant care is provided;
3. Administration of medication;
4. Prevention of and response to an emergency due to food and allergic reactions;
5. Building and physical premises safety;
6. Prevention of shaken baby syndrome and abusive head trauma if infant care is provided;
7. Emergency preparedness and response planning for an emergency resulting from a natural disaster or man-caused event;
8. Handling and storage of hazardous materials and the appropriate disposal of bio contaminants;
9. Precautions in transporting a child (if the program provides transportation for any purpose);
10. Recognition and reporting of child abuse and neglect;
11. Pediatric first aid;
12. Pediatric cardiopulmonary resuscitation (CPR); and
13. Child development.

B. Before a provider may care for children without supervision, the provider must complete orientation training in each of the areas listed in this section.

C. All providers must obtain annual training in the topic areas identified in 45 C.F.R. § 98.41, in effect on September 30, 2016, or as identified by the department. Training must be documented and relevant to the provider's position as determined by the department. Training may include on-site or online classes.

D. Pediatric cardiopulmonary resuscitation renewal may not be included in annual training.

E. Each director and provider of center and school-age programs counted in staff-child ratios shall complete ten hours of annual training.

F. Orientation training hours qualify as annual training hours for each provider in the year the training was completed.

G. Every five years, all providers shall complete additional advanced training in each of the training areas listed in § 67:42:17:17.

Intent

The purpose of orientation is to ensure all providers have knowledge of practices, policies, and procedures that keep children safe and the standards that the center must meet. Providers come to a program with a variety of education, knowledge, experience, and strengths, as well as areas that need more attention. Initial orientation prepares providers for what they will encounter in the facility and classroom setting. Research has shown that providers who are better trained are better able to prevent, recognize, and correct health and safety problems. Annual ongoing training offers providers an opportunity to learn the newest techniques for addressing children's behaviors, to discover the latest findings on what children need as they develop, and to refresh and re-energize their skills.

This training is required for all providers, directors, and those with unsupervised access to children. The federal Child Care and Development Block Grant, reauthorized in 2014, requires all child care providers receiving federal subsidies to complete orientation within 90 days of employment and before caring for children unsupervised. The grant also requires annual ongoing training as well as progressive training to be completed by all providers and directors.

Clarification

Providers must complete and have documentation of orientation within 90 days of employment. Until the provider has completed orientation training, they may not be unsupervised with children. Substitutes and volunteers counted in the staff-child ratio or that have unsupervised contact with children are providers and must meet orientation training requirements. Supervised contact may look different for programs depending on the layout of the facility and proximity of classrooms. A provider who has not completed orientation training may be supervised by another provider, who has completed their orientation training, if they are close enough to monitor their interactions with children on a continual basis and intervene if needed. For further guidance, please contact your local licensing specialist.

In addition to the required health and safety topics, programs may have their own individual orientation that includes job duties, expectations, and policies around issues such as emergency preparedness, confidentiality, supervision, maintenance of ratios, transportation, and cell phone usage in classrooms. It is also important that every provider, not just the director, understands all the regulations pertaining to a licensed facility. Clear communication of goals and objectives during orientation training can ensure orderly operations, enhance employee performance, and reduce stress.

Ongoing annual training should build upon the original orientation training that was developed as entry-level training. Directors may wish to assess providers' knowledge and skills to identify subject areas most needed for their ongoing development and effective center operation. Too often, providers make training choices based on what they like to learn about and not the areas in which

their skills could be improved. The director may wish to conduct an annual needs assessment with each individual provider to plan the training that would be of the most benefit to them. The department may evaluate if a training topic is relevant to the provider's position, e.g., safe sleep training for a school-age care provider.

Training topics should cover information regarding child development and early childhood education, supporting the provider in developing and refining skills that assist in meeting the emotional, physical, intellectual, and social needs of the children. Training in child guidance techniques can help providers encourage children to develop self-control and exhibit more acceptable behaviors. You may wish to refer to the different training categories, based on the Core, Knowledge, and Competencies (https://sdece.org/sd-core-knowledge-and-competencies/), to help ensure providers receive a well-rounded base of knowledge about child care.

Once completed, orientation training is not required if the provider changes employment. However, verification of all orientation training certificates needs to be on file with the new provider.

The annual professional development training requirement timeframe is determined by the program. It is to be the same for all providers (i.e., calendar year or fiscal year or school year). All providers, regardless of the hours worked, must meet the 10-hour annual training requirement. Employees working in programs which only operate during the summer months and regular substitutes must complete four hours of annual training. Occasional substitutes are only required to maintain current CPR certification, and Advanced Level II health and safety training, in addition to meeting the orientation training requirement. Training will not be prorated for leave of absence such as maternity leave. Any new providers who start employment within that year will be allowed to meet a pro-rated training schedule of 0.8 hours of training per month employed. Ongoing annual training will be accepted only for the employment year in which the training was completed. However, if a provider fails to obtain required training hours within the annual timeframe, they must complete those hours within an agreed upon timeframe to be in compliance and not count them again for the year in which they were completed.

If a provider has completed a college course in an applicable training area, a copy of the transcript indicating successful completion of the course will be accepted for the training year it was completed. The provider will receive 15 hours of annual training for each credit hour (e.g., a 3-credit college course will count for 45 hours of annual training). Please contact your licensing specialist if it is uncertain if a college course is applicable.

Pediatric CPR training hours may be counted initially as part of orientation training, but training hours to renew CPR certification in subsequent years are not counted toward the annual training requirement.

DSS Office of Licensing and Accreditation and Child Care Services (CCS) collaborates with five Early Childhood Enrichment (ECE) sites across the state to deliver a variety of services focused on parents, child care, and after-school providers. ECE offers a variety of evidence- and research-based professional development opportunities including technical assistance, coaching, and training.

All new employees can access the online Orientation to Child Care course that includes interactive features and additional learning feedback. It addresses the required health and safety topics except pediatric CPR (also see Section XV on first aid and CPR). Ongoing training is accessible to child care providers across the state through in-person, online, and on-site delivery. Watching videos, reading materials, or other passive methods of training will not be counted toward annual training requirements.

Directors, providers, and substitutes are required to complete Advanced Level II Health & Safety Training in the health and safety topics initially covered during orientation training no later than five years after completion of the initial orientation training. If a provider changes jobs, they still must meet the five-year timeframe regardless of when they changed employment. In addition, Level III Health & Safety Training must be completed within ten years of completing the initial orientation training.

Indicators

- ☑ For new hires, review all training records to include orientation training topics, dates, and hours of training to verify that all required training topics were covered, and that orientation training wascompleted within 90 days of employment. If an employee was hired within the previous 90 days of the inspection date and the orientation training has not been completed, it will not be cited as non-compliance.
- ☑ During annual inspections, review a minimum of 20% of all provider training records. For programs employing 10 or fewer providers, all training records will be reviewed.
- ☑ Verify that the Level II health and safety training topics were completed within five years of the completed initial orientation training.
- ☑ Verify that the Level III health and safety training topics were completed within ten years of the completed initial orientation training.

Resources and Forms

The DSS website provides information on orientation training and progressive health and safety training at Education Opportunities (sd.gov).

Additional information on Pathways to Professional Development and the career lattice are at Career Lattice Requirements (sd.gov).

CFOC 4th ed. has a full chapter on Professional Development/Training – Standards 1.4.1.1 – 1.4.4.1, pgs. 21–30, that address topics including pre-service and orientation training topics, training on the care of children with special health care needs, ongoing professional development, and sources of training. CFOC4 pdf- FINAL.pdf (nrckids.org).

For more information on ECE services, locations, and orientation and ongoing training, go to https://sdece.org/.

Caring for Our Children Basics (CFOCB) outlines a set of voluntary, foundational health and safety standards for early care and education programs. https://childcareta.acf.hhs.gov/cfoc

Supervision, ratios, and group size

ARSD 67:42:17:19 – 67:42:17:22

A. A center provider supervising children must be in the same room with the children or on the playground with the children and must be able to see or hear the children at all times.

B. If children are in a school-age program, the provider must be able to hear or see the children, at all times, and must be close enough to intervene at all times.

C. A center or school-age program must maintain the following ratios:

1. Five children to one staff for children up to three years of age;
2. Ten children to one staff for children three years through four years; and
3. Fifteen children to one staff for children five years and over.

D. A program that serves twenty or fewer children and routinely operates a mixed age group shall meet a ratio of ten children to one staff. Each provider may care for a maximum of four children under the age of two, with no more than two children under the age of one.

E. A center program that serves more than twenty children in a mixed age group must:

1. Maintain a ratio of five children to one staff, if the group includes three or more children under the age of three; and
2. In all other circumstances, maintain the children to staff ratio that is based on the age range of the majority of children in the group.

F. Children of program employees must be included in determining the children to staff ratio.

G. Maximum group sizes for center and school-age programs are determined by individual room capacity, and all space used must be approved for care by the department.

1. The provider shall ensure the number of children in care at any given time does not exceed the capacity identified on the license;
2. Children of program employees must be included in the group size;
3. The provider shall ensure children to staff ratios are maintained in all settings, including large indoor and outdoor space;

4. In spaces where more than twenty children are allowed, providers shall identify which children each provider is responsible to supervise; and
5. When room capacity does not align with the ratio requirements, a maximum of three additional children may be included in the room capacity as long as ratios are maintained.

Intent

Supervision is basic to safety and the prevention of injury, and it is the most important element in providing safe child care. A child's safety depends on providers knowing where the child is and what they are always doing. Providers must actively monitor children's activities by being able to see and hear children and respond quickly as needed.

Staff-child ratios and group size matter. Providers need to provide watchful oversight as well as engage in thoughtful and intentional interactions that lead to nurturing relationships with children. Research has shown that lower ratios and smaller group size are related to positive outcomes for children, including reduced likelihood of injuries and illness, increased adult-child interaction, less aggressive behavior, and more cooperation among children. Smaller groups for infants and toddlers are especially important to ensure safe evacuation in case of an emergency. Caring for too many young children increases the possibility of stress to the provider and may result in anger or frustration.

Mixed-age groupings allow for flexibility in the grouping of children to accommodate developmental needs, fluctuations in enrollment of a particular age group, and maintaining staff-child ratios due to fluctuations in attendance throughout the day.

Group size is the number of children assigned to a team of providers in an individual classroom or defined space within a larger room. While lower ratios and smaller groups sizes are preferable, these standards have a significant fiscal impact on a program and the cost to parents and so must be considered.

Clarification

Providers who are involved, aware, and appreciative of young children's behaviors are in the best position to supervise and safeguard their well-being. Active and positive supervision involves:

- Knowing each child's abilities;
- Establishing clear and simple safety rules;
- Being aware of and scanning for potential safety hazards;
- Placing yourself in a strategic position so you are able to adapt to the needs of the child;
- Scanning play activities and circulating around the area;
- Focusing on the positive rather than the negative to teach a child what is safe for the child and other children; and
- Teaching children the developmentally appropriate and safe use of each piece of equipment (e.g., using a slide correctly, feet first only).

Ultimately, carefully planned environments, including staffing that supports nurturing, individualized, and engaged caregiving, and well-planned, responsive care routines support active supervision in early childhood environments.

Children like to test their skills and abilities, especially on playgrounds, which can result in serious injuries. Not all children have an innate sense of danger and therefore need adult guidance to keep them safe. Providers should be positioned around the playground to interact with and supervise all the children but not engage in prolonged dialogue with any one child or other provider.

Many programs regularly count children when leaving or entering a new area, and during various times throughout the day to ensure that all are accounted for. To avoid miscounting or overlooking children in a group, it is best to use face-to-name recognition to account for children.

If bathrooms in centers are not adjacent to the classroom, supervision must be provided when children leave the classroom. Other times that may require additional supervision are when children are toilet training, during drop-off and pick-up times, and during field trips.

Adequate lighting should be provided in areas where children are napping. Lighting in a room is adequate if a person's eyes do not need to adjust for the person to be able to see upon entering the room. This ensures that children are not engaged in activities that may be harmful to themselves or others. In addition, it avoids children getting stepped on when others are moving around in a classroom. The providers should be able to see children's movement during nap time and must remain awake.

Children need spaces, indoors and out, in which they can withdraw for alone-time or quiet play in small groups. However, program spaces should be designed with visibility that allows constant unobstructed adult supervision to ensure children's safety. During transitions between rooms or to and from the playground or vehicles, providers must ensure that no child is left behind. Immediately prior to closing at the end of the business day, the provider responsible for locking the center should inspect the entire premises to verify that no child is left on the premises.

Programs should evaluate which age groupings and ratios best meet children's and provider's needs. Some programs may choose mixed-age groupings all day or only at the beginning and end of the day. When using mixed-age groupings, each provider is expected to know what children are in their group that they are responsible for supervising. There should also be a minimum level of separation established between groups. Programs are encouraged to contact their licensing specialist for additional guidance specific to their environment or ratios.

In mixed-age groups, the staff-to-child ratio is based on the age range of the majority of children. However, in a mixed-age group that includes three or more children under age three, a 1:5 ratio is required. Otherwise, the ratio is based on the majority age group.

In addition, when a mixed-age group includes an equal number of preschool-age children and children ages five and older, the 1:10 ratio must be followed.

Examples:

- A group of 3 three-year-olds, 5 four-year-olds, and 2 five-year-olds → majority preschool age → 1:10 ratio.
- A group of 6 four-year-olds and 9 five-year-olds → majority five-year-olds → 1:15 ratio.
- A group of three and four year old children that includes three two-year-olds → 1:5 ratio required.

- A group of 7 preschool-age children and 7 children age five and older → equal distribution → 1:10 ratio applies.

Programs licensed to serve 20 or fewer children and routinely operate with mixed age groups may follow a staffing ratio of no more than 10 children to 1 staff member at all times. Within this ratio, each provider may care for a maximum of four children under the age of two, and no more than two of those children may be under the age of one. These limits apply regardless of the total number of children present and are intended to ensure appropriate supervision and care for younger children within a mixed-age setting.

Directors should monitor staff-child ratios throughout the day, and providers should know to alert the director when maximum ratios are reached. Sufficient employees must be maintained to evacuate the children safely in case of emergency. Providers should be aware how many children are in their group at any given time. The owner's, director's, or provider's children are included in the child-staff ratio.

While center and school-age program providers are required to remain in the classroom when children are awake and active to count in the staff-child ratio, only one provider is required to be in the room during nap time if all children are resting quietly or sleeping. One provider may be able to supervise two adjoining rooms if they stand in the doorway or go back and forth frequently. If this is a practice that is followed, the appropriate number of providers need to remain on the premises to ensure the staff-child ratio is maintained for *each* classroom in the event the children awake unexpectedly or an emergency situation such as a fire.

To ensure both visual and auditory supervision is provided, all separate infant and toddler nap rooms are to have a window, open door, or video camera monitor for sight, and an open doorway or a monitor for hearing.

The providers counted in the staff-child ratios are only those employees providing direct care and supervision to active children. This would not include administrative, custodial, or kitchen staff who are not in the room with children. In programs licensed to serve 20 children or fewer, the cook may be included in the staff-child ratio if providing direct care to children. The children's physical safety and child care routines require a provider whose time and attention are not split between too many demands, including distractions from electronic devices. Providers should not use electronic devices for personal activities while they are responsible for the supervision of children.

Remember that supervision and staff-child ratio requirements also apply to transportation, field trips, and swimming activities, but these may need additional providers to keep children safe. When transporting children to and from school, the staff-child ratio requirements do not need to be followed. This exemption does not include other circumstances such as transporting children on field trips.

In addition to the requirements under transportation, appropriate supervision includes not leaving a child of any age unattended in or around a vehicle, even if buckled in seat restraints. Consideration should be given to whether the driver can focus on driving tasks while supervising children. This is especially important with young children who will be sitting in close proximity to one another in the vehicle and may need care during the trip. In any vehicle making multiple stops to pick up or drop off children, having additional supervision permits one adult to manage the transition while the other adult supervises the children remaining in the vehicle. A count of children should be conducted prior to leaving for a destination, before returning to the center, and upon arrival to ensure that no child is left in the vehicle.

Close supervision is also needed on field trips as there is a higher risk to children when their surroundings change or there is a change in routine. When children are excited or busy playing in unfamiliar areas, they are likely to forget safety measures unless they are closely supervised. The director may wish to work with providers on how to assess and have a plan to address potential hazards away from the center.

Constant and active supervision should be maintained when any child is in or around water. An adult should remain in direct physical contact with an infant at all times during swimming or water play, which includes wading. Whenever children one year and up to five years of age are in or around water, the supervising adult should provide “touch supervision,” keeping swimming children within arm’s reach and in sight at all times.

If the provider contracts directly with someone to provide a service (e.g., driver, gymnastics instructor) who does not meet employee qualifications including training and background screenings, providers are required to have written parental permission if children are supervised by an individual who is not employed by the program.

When caring for a child with special needs, the ratio may need to be adjusted to meet each child’s needs. Providers need the time to encourage children with disabilities to participate comfortably in program activities while still meeting the needs of other children in care.

For three- and four-year-old children, the size of the group may be even more important than ratios. Preschoolers require continuing adult support and guidance while experiencing independent, self-initiated play and other activities.

Group size is determined by individual room capacity as designated in the center’s floor plan. However, when room capacity does not align with the ratio requirements, a maximum of three additional children may be included in the room capacity as long as ratios are maintained. Flexibility with room capacity, as allowed in ARSD 67:42:17:19, should not exceed the maximum license capacity.

Allowing three additional children to be included in the individual room capacity recognizes the fiscal impact of maximizing ratios while wanting children to have space to move, play and safely evacuate in the event of an emergency. Prior to making any changes in expanding the room capacity to meet ratio, the licensing specialist is to be notified and provide approval. The licensing specialist will evaluate the space to ensure the increase of children will not compromise children’s safety. An example if approved: the room capacity for the three-year-old room has been determined to allow 8 children during the floor plan review, two additional children may be served in the room to allow for a 1:10 ratio to be followed to maximize the ratio requirements. No more than three additional children over the determined individual room capacity may be permitted upon approval.

Because adequate supervision is more difficult in groups of more than 20 children, center and school-age program providers must be assigned as primary caregivers and providers must be aware of which children they are responsible for when a specific group of children share the space. Spaces include classrooms, gyms, dining rooms, and playground space. The different groups of children may have different schedules (e.g., group one has outside time when group two has circle time and vice versa). Children may sit for lunch and group activities with their assigned provider or team of providers.

In accordance with SDCL 26-6-15.1, programs licensed to serve 20 children or fewer may care for no more than three additional children, and programs licensed to serve more than 20 children may care for no more than 20% of their capacity in the following situations:

- During the before- and after-school hours if the children are beyond the age of kindergarten. This does not apply to non-school days including summer.
- Care is needed due to an emergency situation or special circumstance such as school cancellation due to weather, emergency situation experienced by the child's regular provider, illness or emergency in child's family, child's parent called unexpectedly to work, emergency foster placement, and fire or natural disaster with child's regular provider. Emergency or special circumstances do not include planned non-school days or school summer vacation.
- Staff-child ratios must be followed.

Indicators

☑ Observe provider supervision of children indoors and on the playground for their attention to children's needs. For center and school-age programs, note if providers are leaving classrooms or groups unattended, if providers are positioned where they cannot observe all children in their care, and if there is adequate lighting during nap time.

☑ Observe if providers are attentive to children during meal times and if children are engaged in potentially harmful or inappropriate play without a response or intervention from providers.

☑ If the bathroom is not adjacent to the classroom in center and school-age programs, discuss how the provider adequately supervises children. Do all children go the bathroom at one time or does supervision depend on the distance between rooms, the number and ages of children going to the bathroom at once, etc.?

☑ If a provider is on an electronic device and there is a concern with supervision, the licensing specialist could ask for clarification on the reason for use of the device, e.g., personal or program use.

☑ Count the number of children and providers in all areas where children are present to assess proper ratios. Confirm with the director or provider the children's ages or check children's records for confirmation, if needed.

☑ If applicable (e.g., complaint or incident investigation or to check ratios during night-time care), check staffing schedules and children's attendance records.

☑ In center or school-age program spaces for more than 20 children, confirm that providers are aware of their responsibility to supervise specific children.

☑ In center and school-age programs, compare the floor plan's room capacity with the number of children present.

Resources and Forms

CFOC 4th ed. Standards 1.1.1.3, 1.1.1.4, and 1.1.1.5, pgs. 6–7, offer additional rationale and recommendations for ratios for children with special needs and during transportation and swimming. CFOC4 pdf- FINAL.pdf (nrckids.org).

The Active Supervision Toolkit (hhs.gov) was developed by the Office of Head Start and describes how to implement six strategies to better supervise young children and offers links to many additional resources and tools.

The National Association for the Education of Young Children offers the Program Administrator Guide to Evaluating Child Supervision Practices that provides a proactive approach to improve program policies, procedures, and practices related to supervising children. Supervision Resource_0.pdf (naeyc.org). 2016.

Caring for Our Children Basics (CFOCB) outlines a set of voluntary, foundational health and safety standards for early care and education programs. https://childcareta.acf.hhs.gov/cfoc

Disease prevention and control

ARSD 67:42:17:24

A. Before a child may be admitted to a licensed program, the provider must require a child's parent or guardian to submit a statement signed by a licensed physician, physician's assistant, certified nurse practitioner, or community health nurse, or an immunization record from the South Dakota Immunization Information System showing that the child meets the minimum immunization requirements according to 45 C.F.R. § 98.41(a)(1)(i)(A), in effect on September 30, 2016.

B. The provider shall ensure that immunizations of all children are current.

1. For children who begin the series late or are more than one month behind in immunizations, the documentation must show progress toward achieving immunization requirements, as determined by a licensed physician or other licensed practitioner.
2. A grace period may be approved by the department for a child experiencing homelessness or a child in foster care.

C. A child is exempt from meeting the minimum age-specific immunization levels if:

1. The child's parent or guardian has certification from a licensed physician or other licensed practitioner, stating that the physical condition of the child is such that an immunization would endanger the child's life or health; or
2. The child's parent or guardian has signed a written statement that the child is an adherent to a religious doctrine whose teachings are opposed to such immunizations.

Intent

Routine immunizations at the appropriate age are the best means of protecting children against vaccine-preventable diseases. Immunization is particularly important for children in child care because preschool-aged children have the highest age-specific incidence or are at high risk of complications from many vaccine-preventable diseases. Child care settings present unique challenges for infection control due to the highly vulnerable population, close interpersonal contact,

shared toys and other objects, and limited ability of young children to understand or practice good respiratory etiquette and hand hygiene.

Clarification

The following South Dakota Department of Health vaccine schedule should be followed to ensure current vaccinations are on file for children in care.

REGISTERED AND LICENSED CHILD CARE PROGRAMS
IMMUNIZATION SCHEDULE

Effective November 1, 2016

The chart below indicates the age, or age range, each immunization must be obtained for children enrolled in a registered or licensed child care program. If a child has a medical reason for not receiving an immunization, or is behind in receiving immunizations, an explanation from the child's doctor is to be included in the child's file. If immunizations are not given due to a parent's religious belief, a parent explanation must be included in the child's file.

Vaccine	Birth	1 Mo	2 Mo	4 Mo	6 Mo	12 Mo	15 Mo	18 Mo	19-23 Mo	4-6 Yr
Hepatitis B (Hep B)	#1	#2			#3					
Diphtheria, Tetanus, Pertussis (DTaP)			#1	#2	#3		#4			#5
Haemophilus Influenzae Type b (Hib)			#1	#2	#3	#4*				
Inactivated Poliovirus (IPV)			#1	#2	#3					#4
Measles, Mumps, Rubella (MMR)						#1				#2
Varicella (Chicken Pox)						#1				#2
Pneumococcal (PCV)			#1	#2	#3	#4				
Hepatitis A (Hep A)						2 doses, 6 mo. apart				

= Immunization is to be given within the range of time

Combination Immunizations Often Seen on Immunization Records:
Pediarix = DTaP + Hep B + Polio
Pentacel = DTaP + Hib + Polio
Kinrix = DTaP + Polio
MMRV = MMR + Varicella
Vaxelis = DTaP + Hep B + Polio + Hib (given at 2-4-6 months, just as Pediarix and Pentacel are)

*The Pedvax Hib and COMVAX series are three dose Hib series and all other Hib series are 4 doses.

Providers can access the South Dakota Immunization Information System to check immunization records for children in their care. Access can be requested through the Department of Health. For more information on this option, programs can contact the South Dakota Department of Health at 605-773-4783 or go to https://doh.sd.gov/topics/immunizations-vaccinations/request-copy-of-immunization-record/ .

If a child is enrolling in child care or if they need an updated immunization to meet the guidelines and they do not have a documented exemption, the director should request that the parent provide documentation of a scheduled appointment or arrangement to receive immunizations.

Providers are encouraged to establish a routine for periodically reviewing and updating all children's records to help ensure that immunizations are up to date.

For children exempt due to religious reasons, a sample form may be accessed in the Resources and Forms section below. A medical statement from a licensed medical practitioner must be in a child's file for medical exemptions. The religious exemption form or medical statement shall be included in each child's record in lieu of vaccinations.

Important note about vaccinations:

- If a child is not current with Hib and/or pneumococcal vaccinations, these vaccinations are not recommended to normally healthy children after age five.
- Once a child turns seven years old, the DTaP recommendation drops, and Tdap becomes the recommended method to gain diphtheria, tetanus, and pertussis vaccination.

Two exemptions in federal law to having immunization records prior to enrollment are in the event of a family who is experiencing homelessness or a child in a foster care placement. For these two situations, if the record is not accessible at the time of enrollment, the child can be enrolled, and the record is to be obtained and placed in the file as soon as possible. Notify your licensing specialist if there is a delay in obtaining an immunization record beyond two weeks after the child is enrolled.

Indicators

☑ Review immunization records annually through an on-site compliance inspection.

☑ View documentation of a scheduled appointment or arrangement to receive immunizations.

Resources and Forms

The recommended Childhood and Adolescent Immunization Schedule – 0-18 Yrs child combined Schedule.

An Immunization Affidavit for religious exemptions to immunizations is available on the DSS website at https://dss.sd.gov/formsandpubs/.

Caring for Our Children Basics (CFOCB) outlines a set of voluntary, foundational health and safety standards for early care and education programs. https://childcareta.acf.hhs.gov/cfoc .

ARSD 67:42:17:24

D. If a child becomes ill while at a day care, the provider must separate the child from other children and notify the child's parents. If any child in the program contracts a communicable disease, the provider must notify the Department of Health. The program provider shall follow the Department of Health's recommendations for addressing a situation involving a communicable disease.

E. To prevent the spread of an infestation or infectious disease, a program shall provide an individual storage unit or container for each child's personal articles.

Intent

Ill children are separated from other children to prevent a contagious illness from being spread. Young children are in close contact with each other, not observing cough and sneezing etiquette, and sharing toys, so that providers face challenges in maintaining environmental sanitation.

Individual storage of children's personal items is one strategy to reduce the spread of disease.

Reportable diseases pose a significant risk to children and require additional safeguards such as reporting requirements and determining when a child can safely return to child care.

Clarification

Parents must be notified when children show symptoms of illness so they can determine how they wish to respond (e.g., use of medication, contacting a physician, etc.).

The care of children who are mildly ill in group care settings is an inevitable reality. During the winter, many children have a common respiratory illness at any one time and do not need to be excluded from the program unless their condition meets exclusion criteria. The South Dakota Department of Health provides a list of Recommendations for Temporary Exclusion from a Child Care Setting at https://doh.sd.gov/media/vl4az1b0/temporary-exclusion-child-care.pdf.

Exclusion of children with fevers is recommended; however, the provider may determine when a child should be excluded based on a child's temperature. Provisions should be made for children's comfort and supervision when separated from other children if waiting for a parent to pick them up.

The Department of Health can provide recommendations for separation, care, and readmittance. Reporting to the Department of Health also gives a licensed program the opportunity to ask any questions related to the disease or what steps to take to prevent the spread of the disease to other children or employees. The South Dakota Department of Health, Division of Communicable Disease can be reached at 605-773-3364 or 1-800-592-1861.

ARSD 44:20:02:02 requires that a person employed by or attending a child care program that has been diagnosed with or is suspected of being a carrier of a reportable disease must notify the Department of Health. For a list of reportable diseases by category and reporting timeframes, see https://doh.sd.gov/topics/diseases-conditions/communicable-infectious-diseases/reportable-communicable-diseases/.

Reportable illnesses are more serious due to their infectiousness, severity, or frequency of occurrence, and they pose a serious public health threat (or the potential for such threat). For these reasons, parents should be given written notification within 24 hours of the program becoming aware of the illness, or by the next working day. This enables parents to closely monitor their children for signs of possible infection and provides valuable information that the parent can share with the child's medical professional.

Head lice infestation in children attending child care is common and is NOT a sign of poor hygiene. If head lice are present, children should avoid any head-to-head contact with other children and the sharing of any headgear while finishing out the day. As long as treatment is started before returning the next day, children or employees do not need to be excluded.

Individual storage spaces should be labeled with the child's name, a photograph of the child, or other symbol the child recognizes as their own.

Indicators

- ☑ Discuss with the director their response to both mild illnesses in children and contagious and reportable diseases in program employees and children.
- ☑ View individual storage units or containers for each child's personal articles and clothing, and check bathrooms for appropriate storage of items such as combs and toothbrushes.
- ☑ Review individual program policy information if available.

Resources and Forms

South Dakota Department of Health Reportable Communicable Diseases and Disease Fact Sheets are available at https://doh.sd.gov/topics/diseases/infectious-diseases/reportable-diseases-in-sd/ and https://doh.sd.gov/diseases/.

South Dakota Department of Health Recommendations for Exclusion is available at https://doh.sd.gov/media/vl4az1b0/temporary-exclusion-child-care.pdf.

ARSD 67:42:17:25

F. All equipment, utensils, kitchenware, dining tables, and food contact surfaces of equipment must be washed, rinsed, and sanitized after each meal.

G. Toys capable of being placed in a child's mouth shall be cleaned and sanitized daily, using a solution approved by the department.

Intent

Cleaning and sanitizing food contact equipment, surfaces, and kitchenware are important components of controlling the spread of germs and disease. Outbreaks of infectious diseases and foodborne illnesses have occurred in child care settings, many of which can be prevented through appropriate hygiene and sanitation methods.

All toys can spread disease when children put the toys in their mouths, touch the toys after putting their hands in their mouths during play or eating, or after toileting with inadequate hand hygiene.

Clarification

The food preparation, food service, and dining areas should be cleaned and sanitized before and after use, and protected from contamination. Sponges should not be used for cleaning and sanitizing as they harbor bacteria and are difficult to clean and sanitize between cleaning surface areas.

Dishwashing can be done using a dishwasher or a three-compartment dishwashing process that includes washing in a hot detergent solution, rinsing in clear warm water, and sanitizing with a chemical sanitizing agent by immersing the dish or utensil for a minimum of ten seconds. The wash

water must be kept clean, and the sink refilled as often as necessary. Air-drying reduces the number of microorganisms to safe levels and also reduces residue on the dishes. Towels should not be used to dry or drain clean dishes as they can harbor bacteria that can be spread from one dish to another.

Household bleach mixed with water is a very efficient sanitizer as it is effective, economical, convenient, and readily available. It should be diluted according to the manufacturer's instructions because products contain different percentages of chlorine. If the bleach solution is premixed, the solution should be mixed daily to maintain full strength. Before using any sanitizer other than bleach, contact your licensing specialist for approval to use the product.

Education of program employees regarding routine cleaning procedures can reduce the occurrence of illness in the group of children with whom they work. It is recommended that children are not permitted in the kitchen except as part of a planned, supervised learning experience. The presence of children in the kitchen increases the risk of contamination of food and the risk of injury to children from burns or potentially dangerous appliances.

Toys capable of being put in a child's mouth must be washed, rinsed, and sanitized daily using bleach water or another approved sanitizer. A dishwasher may be used to wash and sanitize those toys that can be placed in a dishwasher. Small toys with hard surfaces can be set aside for cleaning by putting them into a dish pan labeled "soiled toys." This dish pan can contain soapy water to begin removal of soil, or it can be a dry container used to bring the soiled toys to a toy cleaning area later in the day.

Having enough toys to rotate through cleaning makes this method of preferred cleaning possible.

Indicators

- ☑ Discuss the process used to sanitize food service items and toys and ask to see the sanitizing product used. Are tables sanitized before and after each use? Are toys capable of being put in a child's mouth sanitized daily?
- ☑ Observe cleanliness of equipment, utensils, kitchenware, and food contact surfaces of equipment.
- ☑ Review individual program policy information if available.

Resources and Forms

See CFOC 4th ed. Appendix J: Selecting an Appropriate Sanitizer or Disinfectant, p. 484, for more information on safely preparing and using bleach solutions, identifying alternatives to chlorine bleach, and reading product labels. CFOC4 pdf- FINAL.pdf (nrckids.org).

ARSD 67:42:17:25

H. All providers, program employees, and children shall wash their hands with soap before preparing food or beverages, eating, handling food, or feeding a child, and after changing a diaper, using the toilet, helping a child use a toilet, or coming into contact with bodily fluid.

Intent

Handwashing is the most important way to reduce the spread of disease and infection. Providers and children may carry infectious organisms without displaying any symptoms, and many are contagious before they experience a symptom. However, child care programs that have implemented good hand hygiene techniques have consistently demonstrated a reduction in disease transmission.

Clarification

The CDC recommends these handwashing steps:

- Wet your hands with clean running water and apply soap;
- Rub your hands together to make lather and scrub them well and be sure to scrub the backs of your hands, between your fingers, and under your nails;
- Continue rubbing your hands for at least 20 seconds (tip: hum the “Happy Birthday” song twice);
- Rinse your hands well under running water;
- Dry your hands using a clean towel or air dry; and
- Use a paper towel to turn off the faucet.

Until the infant or toddler is old enough to be raised to the faucet and reach for the water, you should wash the infant’s hands using an individual cloth or disposable towel with soap, followed by a cloth or disposable towel used to rinse with clear water and dry.

Sanitizers and pre-moistened cleansing towelettes do not effectively clean hands and should not be used as a substitute for washing hands with soap and running water. Hand sanitizers can be used by providers during the course of the day when visible soiling is not present, or when running water is unavailable or impractical. Hand sanitizers should not be used on children under 24 months of age.

While not required, some programs encourage children to also wash their hands after handling animals, playing in water or sand, or playing outdoors. Providers may additionally wish to consider the following as important times to wash hands:

- After handling animals or animal waste;
- After sneezing or handling a child’s sneeze or wiping of nose;
- After handling garbage or soiled clothing or bedding;
- After using any cleaners or toxic chemicals;
- After removing gloves;
- Before and after administration of medications; and
- After applying sunscreen or insect repellent.

When supplies are lacking or are out of reach, it discourages children from practicing proper handwashing and toileting techniques. Shared cloth towels should not be used since they can transmit infectious disease.

Providers should teach children how to wash their hands and then monitor children's hand hygiene practices. Programs often post handwashing steps at each sink used by adults and children.

Disposable or single-use towels reduce disease transmission as long as they are discarded after each use. When cloth towels are used, they should be used one time by only one child and then laundered.

Washcloth handwashing is recommended 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 should be used only once for each child before laundering.

Indicators

- ☑ When possible, observe hand hygiene, especially around food handling and toileting. If not observed, ask the director, providers, and kitchen staff to describe the program's procedure for hand hygiene.
- ☑ Observe if children are assisted with handwashing if needed (e.g., help using a stool, pumping the soap dispenser, reaching the faucet knobs or paper towels, and washing all surfaces of their hands).
- ☑ Check children's sink areas for soap and individual towels or hand dryers.

Resources and Forms

Hand Washing: A Powerful Antidote to Illness - HealthyChildren.org includes a video from the American Academy of Pediatrics on how to make handwashing fun.

The CDC's Hand Hygiene in Schools and Early Care and Education Settings provides steps to promote hand hygiene, when and how to use hand sanitizer, and handwashing promotional materials including printable posters and fact sheets.

Caring for Our Children Basics (CFOCB) outlines a set of voluntary, foundational health and safety standards for early care and education programs. https://childcareta.acf.hhs.gov/cfoc

Safe sleep practices

ARSD 67:42:17:26

A. A nap mat, blanket, or other sleep surface, other than the floor, for children over one year of age must be available for each child during nap time.

B. A sleep surface must be maintained in good repair.

C. A provider shall follow the safe sleep practices in *Caring for Our Children: National Health and Safety Performance Standards*, 4th Edition, for infants under the age of one.

Intent

Safe sleep practices help reduce the risk of sudden infant death syndrome (SIDS). Each year in the United States, approximately 3,500 infants die of sleep-related infant deaths, including SIDS and accidental suffocation and strangulation in bed. While the cause of SIDS is still unclear, 30 years of research has found the risk may be reduced by implementing safe sleep practices such as placing an infant on their back to sleep.

Young children benefit from sleep and rest during the day. Sleeping on a clean and comfortable surface helps children rest, relax, or sleep.

Clarification

The following American Academy of Pediatrics recommendations are included in *Caring for Our Children*:

- Place babies up to one year of age on their back for *every* sleep time. If a baby rolls over on their tummy on their own, they can stay in that position.
- Use a firm, flat, non-inclined sleep surface with a tight-fitting sheet. A firm surface maintains its shape and will not indent or conform to the shape of the infant's head when the infant is placed on the surface. Mattresses should be tight-fitting with no gaps larger than two fingers between the sides of the crib and the mattress.

- If a baby falls asleep in a car seat, swing, stroller, bouncer seat, or infant carrier, move them to a crib or other firm sleep surface. Infants who are younger than four months are particularly at risk because they may assume positions that can create a risk of suffocation or airway obstruction or may not be able to move out of a potentially asphyxiating situation.
- Cribs, portable cribs, bassinets, and play yards are required for infants under the age of one and must meet current Consumer Product Safety Commission (CPSC) requirements. Drop side cribs and stacking cribs are not permitted.
- Keep soft objects and loose bedding that increase the risk of entrapment or suffocation out of the infant's sleep area. This includes blankets, pillows, bumper pads, stuffed toys, and sleep positioning devices.
- Change bedding between use by different children.
- Keep the day care environment smoke-free. State law prohibits smoking in public places, which includes licensed child care programs.
- Do not let babies get too warm. Keep the room where babies sleep at a comfortable temperature. In general, babies should be dressed in no more than one extra layer than a caregiver would wear. Infant sleep clothing should not include hoods, cords, or strings.
- Follow a parent's instructions on the use of a pacifier during nap time.
- Mobiles and other objects that hang over or are attached to an infant's crib must be kept out of the infant's reach. Sound machines, if used, should be positioned as far from the infant as possible, at the lowest effective volume, and should not be placed in or attached to the crib.
- Remember tummy time. Babies need plenty of time spent on their tummy during awake time to strengthen neck muscles.

A note from a medical professional can be accepted if sleep practices are medically necessary that do not align with safe sleep practices (e.g., a child with reflux may need to sleep in an inclined position).

While infants shouldn't get too warm, sleep sacks are a recommended alternative to blankets. Swaddling an infant is not necessary or recommended as there is evidence that swaddling can increase the risk of serious health outcomes, especially in certain situations. Weighted sleep devices should not be utilized.

Providers should consider the light level in the room so that they can see each infant's face, view the color of the infant's skin, and check on the infant's breathing and placement of the pacifier (if used). Bibs and pacifier clips should be removed from an infant during nap time to eliminate a strangulation hazard.

Federal standards have been developed to define sleep environment safety, and providers should make sure that cribs, portable cribs, bassinets, and play yards used in the program meet these standards to protect children and prevent injuries or death. As of 2012, all cribs being used in child care programs must meet these standards. See 5023.pdf (cpsc.gov) for guidance on how to verify that cribs meet the new standards and New Play Yard Standards (cpsc.gov) regarding play yards. Cribs should also be placed away from window blinds or draperies.

Smaller sleep surfaces, such as portable cribs, play yards, and bassinets that meet safety standards of the CPSC can be used and may be more acceptable because they are smaller, more portable, and typically more affordable. If concerns exist about the condition or safety of sleep equipment, the provider may be asked to obtain documentation of compliance with CPSC/ASTM standards.

As soon as a child can stand up, the mattress should be adjusted to its lowest position. To prevent children from sustaining injuries, providers should closely observe a toddler's efforts to climb out of a crib and transition them to another sleep surface. Most toddlers can climb over the crib rail when they are approximately 35 inches tall and between 18 and 24 months of age.

Nap mats, blankets, or another sleep surface provide comfort for a napping child. Cots and mats should be in good repair and of sufficient size to accommodate comfortably the size and weight of the child. Using cleanable, waterproof, nonabsorbent sleeping equipment enables providers to wash and sanitize the sleeping surfaces and minimize the spread of infection. It is recommended that all sleeping equipment and bedding be washed, rinsed, and sanitized when soiled, between uses by different children, and at least once a week when used by an individual child.

Indicators

- ☑ Observe infant sleep practices including infants under one year of age sleeping on their backs on a firm mattress that is tight-fitting without gaps and without any soft objects or loose bedding.
- ☑ Check to ensure cribs are in good repair, free of hazards, and that they meet CPSC and ASTM standards.
- ☑ Verify that infants under one year of age are not allowed to sleep in a car seat, swing, stroller, or infant carrier.
- ☑ Observe that sleep surfaces are provided for napping children and in good repair.

Resources and Forms

The CDC's website at Parents and Caregivers - SIDS | CDC includes a link to the most current safe sleep practices as recommended by the American Academy of Pediatrics for infants under the age of one. It also offers additional recommendations to reduce the risk of SIDS, a CDC safe sleep video, safe sleep resources, and grief resources.

The National Institute for Children's Health Quality provides a safe sleep handout and infographic for child care providers that can also be shared with parents at Safe Sleep Resources for Child Care Providers.

CFOC 4th ed. 3.1.4.1 Safe Sleep Practices, p. 102, and 3.1.4.3 Pacifier Use and 3.1.4.2 Swaddling, p. 105, provide considerations and guidance on safe sleep practices, pacifier use, and swaddling. CFOC4 pdf- FINAL.pdf (nrckids.org).and Early Care and Education Settings | CDC.

Safe Sleep Ambassador Training. https://cribsforkids.org/safe-sleep-ambassador/

Caring for Our Children Basics (CFOCB) outlines a set of voluntary, foundational health and safety standards for early care and education programs. https://childcareta.acf.hhs.gov/cfoc

Medication administration

ARSD 67:42:17:27 & 28

A. Before any medication is administered to a child, permission of the parent or guardian must be documented and must include the name of the child, the name of the medication, and the dates, times, and dosage of the medication.

B. The medication must be provided by the parent and kept in the original container, with the original label. The label for a prescription medication must contain the child's name, the amount and frequency of dosage, the expiration date, the physician or other licensed practitioner's name, and instructions for storage.

C. The medication must be returned to the parent when no longer needed or expired.

D. The provider shall document, in the child's record, any medication administered to a child and shall include the dose, name of the child, the time and date administered, and the name of the person administering the medication. The documentation must be retained for at least six months and be made available to the child's parent upon request.

E. Medication shall be stored in a place which is inaccessible to children.

F. Medication requiring refrigeration shall be placed in a nonabsorbent container and labeled "medications."

Intent

Keeping children safe around medications and making sure the right child gets the correct dosage of medication at the right time is a serious responsibility. Medications and over-the-counter products can be dangerous if given or taken incorrectly. Proper procedures and documentation of parental permission and administration of medications provides protection for both the child and the program. In addition to identifying dosages and frequency, labeling also provides important information on proper storage and expiration dates. Medication sometimes looks or tastes like candy to children and therefore must be always inaccessible. Placing refrigerated medications in another container helps prevent spillage of the medications on food.

Clarification

For the purpose of these regulations, medication is defined as any substance that is used to relieve pain or treat disease, or any substance prescribed by a doctor. It includes non-prescription or over-the-counter medication, excluding topical ointments such as diaper ointment, insect repellant, or sunscreen.

The director of a program must ensure that policies on medication handling, storage, and administration are understood and adhered to by all employees.

When a permission form is completed, the provider should review it to ensure that all needed information is provided. When administering over-the-counter medications, such as teething medications to infants or toddlers, parental permission should be obtained monthly to cover a 30-day period of administration as needed. If prescription medication is required to be administered daily or for emergency medications such as an inhaler or EpiPen, programs should ask parents to complete a new permission form each time a prescription is renewed or changed. If medication, such as Benadryl, is required as part of a child's allergy treatment plan, parental permission can be obtained annually; however, the written medication permission should be updated when a medication or dosage to be administered changes. If it is no longer needed, the medication must be returned to the parent. If it cannot be returned, the medication should be disposed of properly and documentation of the disposal kept. Medication may only be administered to the child it is intended for.

It is the responsibility of the program to ensure that medication is brought to the program in its original, labeled container. Over-the-counter medications do not require a note from a medical practitioner but should be kept in the original container as sold by the manufacturer and labeled by the parent with the child's name and any specific instructions such as the amount and frequency of dosage. A drug container without a label or with an illegible label should not be accepted.

A program can decide whether to require parental permission for topical products such as diaper cream, sunscreen, or insect repellent. Getting permission can protect providers from having an upset parent when a product is used on their child without their knowledge. The American Academy of Pediatrics recommends the use of sunscreen for children six months and older during any outside play for the prevention of skin cancer even on cloudy days and during the winter as sun reflects off water, snow, sand, and concrete. It should be applied and reapplied according to manufacturer instructions. Insect repellents may be used with children older than two months where there are specific disease outbreaks and alerts. Pump sprays are a better choice than aerosol sprays, and providers should read product labels and confirm that the product is 1) safe for children and 2) contains no more than 30% DEET.

Administering medication requires skill, knowledge, and careful attention to detail. If special knowledge or training is needed to administer a medication, such as an EpiPen, the provider should consult with the parent or a medical professional to ensure the medication can be administered safely and appropriately. Medication must be administered exactly as prescribed on the label and documented so that parents can be made aware of all medications given. The documentation can be in any format as long as it contains the required information. Programs may also wish to document the reason if the medication was not administered (e.g., child absent, medication not brought by the parent).

A sample Medication Administration Form at OLA-107_Medication_Administration_Form.pdf (sd.gov) includes both parent permission and a log of when medications are administered. An online app may

be used by parents for medication permission and by providers to document medication administration if it includes all required information and is readily available to providers.

Programs may choose to assign one primary provider and a back-up provider to dispense all medications and to maintain the documentation. Programs should also document if the child has any negative reactions or side effects from the medication. Because children 24 months of age and younger are in a period of rapid development and are more vulnerable to the possible side effects of medications, extra care should be given to this population. Even common drugs such as acetaminophen and ibuprofen can result in significant toxicity for infants and small children. Inaccurate dosing from the use of inaccurate measuring tools can result in illness or even death.

In emergency situations such as a child with a high fever, the program may obtain verbal authorization from the parent over the telephone for a single dose to be administered followed by a written and signed authorization when the parent arrives at the program. Alternatively, programs may consider requiring written permission from parents by text, email, or app used by the program.

Prescription medications can often be timed to be given at home and this should be encouraged. Because of the potential for errors in medication administration, it may be safer for a parent to administer their child's medicine at home.

If a medication mistake or unintentional poisoning does occur, call your local poison center immediately at 1-800-222-1222. Parents should also be notified if a child was given a medication that was not intended for them.

Medications must be stored out of the reach of children or in locked storage, refrigerated if required, and stored in a nonabsorbent container to keep it separate from food.

Indicators

- ☑ Discuss medication administration policies with the director or review written policies if available.
- ☑ Review medication permission forms to ensure that required information has been obtained from the parent.
- ☑ Check all medications present at the program to ensure the medications are in the original containers, are labeled properly, and have not expired.
- ☑ Check that documentation of medication administration includes all required items.
- ☑ Check to see if medications are inaccessible to children and refrigerated if needed in a labeled nonabsorbent container.

Resources and Forms

CFOC 4th ed. provides a sample medication administration policy in Appendix AA: Medication Administration Packet, p. 522 at CFOC4 pdf- FINAL.pdf (nrckids.org).

A six-minute video entitled Keeping Them Safe: Medication Administration summarizes the importance of having proper policies and protocols on medication administration and answers common questions on labeling, storage, and procedures for emergency medications. Medication Administration | ECLKC (hhs.gov).

A Medication Permission and Administration form is available on the DSS website at https://dss.sd.gov/formsandpubs/.

Caring for Our Children Basics (CFOCB) outlines a set of voluntary, foundational health and safety standards for early care and education programs. https://childcareta.acf.hhs.gov/cfoc

Food and allergic reactions

ARSD 67:42:17:29

A. A provider shall have a written care plan for each child who has a known food allergy. The plan must include instructions regarding any food allergens, steps to be taken to avoid that food, and a detailed treatment plan to be implemented if the child has an allergic reaction.

Intent

An allergy is an immune system reaction that occurs soon after exposure to an allergy-causing food or other substance and typically triggers signs and symptoms such as digestive problems, hives, or swollen airways. In some people, a food or other type of allergy can cause severe symptoms or even a life-threatening reaction known as anaphylaxis. It is therefore critical that *all* providers are aware of children's allergies, and act to prevent exposure to those foods or other allergy substances. A major factor in death from anaphylaxis has been a delay in the administration of lifesaving emergency medication, particularly epinephrine.

Clarification

Providers should be aware of any initial signs and symptoms of an allergic reaction so that they can implement a child's written treatment plan. They should know ahead of time what procedures to follow, as well as their designated roles, during an emergency. The plan should be readily accessible to providers, especially those caring for a child with an allergy.

To ensure that assistant and substitute providers are aware of individual children's food allergies, the information should be noted in the kitchen area and classroom where providers can view them. If a parent requests that other children or families be made aware of their child's food allergy, the program may share that information or post it prominently. If a parent requests that this information be kept confidential, the information may be posted inside a cabinet or kept in a notebook or on a clipboard with a cover sheet.

Indicators

- ☑ Review children's records that include any known allergies and the treatment plan that the parent will want followed if an allergic reaction occurs.
- ☑ Review the written treatment plans for children with instructions on how the program will prevent exposure to that food-related item and respond to any allergic reaction including administration of medications.
- ☑ Ask to see how information on children's allergies is available for providers to see.

Resources and Forms

See CFOC 4th ed. Standard 4.2.0.10, Care for Children with Food Allergies, p. 170, for more information on care plans and additional precautions at CFOC4 pdf- FINAL.pdf (nrckids.org).

Guidance on Completing a Written Allergy and Anaphylaxis Emergency Plan | Pediatrics | American Academy of Pediatrics (aap.org) includes a sample emergency plan.

Written Care Plan for a Child with Allergies form is available on the DSS website at https://dss.sd.gov/formsandpubs/.

Caring for Our Children Basics (CFOCB) outlines a set of voluntary, foundational health and safety standards for early care and education programs. https://childcareta.acf.hhs.gov/cfoc

ARSD 67:42:17:30

B. Providers shall post a weekly menu that indicates meals and snacks to be served that week.

Intent

Advance planning of menus ensures that meals and snacks meet the nutritional needs of children and that the food items needed for the meal will be available. Posting the menu is helpful to parents so they know what their children will be served without having to ask each day. They are also able to then complement that meal with the food being served at home. Parents of children with food allergies may also check menus for any prohibited food.

Clarification

The menu should be posted (i.e., in an entryway or in each classroom where parents can easily see it) or shared electronically.

Indicators

☑ Verify that the menu is posted or shared electronically with parents for that week.

Resources and Forms

See Meal Patterns Tables for the Child and Adult Care Food Program with types and amounts of food and other resources at Nutrition Standards for CACFP Meals and Snacks | Food and Nutrition Service (usda.gov).

USDA Team Nutrition resources include an education nutrition kit for child care programs at https://www.fns.usda.gov/tn/child-care-organization.

Child and Adult Care Food Program, SD Department of Education provides an application, claims forms, and information on snacks, meals, and training opportunities.

ARSD 67:42:17:31

C. An infant shall be fed according to an individual schedule. Propping of a bottle while feeding an infant is prohibited.

Intent

Each infant's needs vary greatly during this critical time of growth and development. Infants should be fed when they are hungry, not necessarily on the same set meal schedule as older children.

When infants are fed based on their needs, they are in control of frequency and number of feedings. This has been found to reduce the risk of childhood obesity. Bottle propping can cause choking and aspiration and may contribute to long-term health issues, including ear infections (otitis media), orthodontic problems, speech disorders, and psychological problems.

Clarification

Developing a feeding plan with parents may be helpful to provide consistency between the program and the child's home. Written feeding instructions ensure that all providers, including substitutes, have clear instructions for feeding infants.

Babies not old enough to hold the bottle have no control to take the bottle out when they have too much milk in their mouth and can choke. Holding infants for bottle feeding is also an important time for face-to-face interaction and should be a warm, loving experience. While it is not required to hold infants for bottle-feeding when they are able to hold their own bottle, it is recommended as an opportunity to nurture the adult-child bond.

Indicators

☑ Talk with providers about infant feeding schedules and observe if infants are held for bottle feeding.

ARSD 67:42:17:31

D. Food, including breast milk and formula, shall be properly stored, kept at the proper temperature, and protected from potential contamination.

Intent

Foodborne illness and poisoning from food are a common occurrences when food has not been properly selected and stored (refrigerated, covered, thawed, reheated). Thawing foods at temperatures over 41 degrees Fahrenheit (°F) promotes the growth of bacteria that may cause illness. Storing perishable foods at safe temperatures in the refrigerator or freezer reduces the rate at which bacteria in these foods multiply.

Clarification

To ensure that children receive the formula or breast milk intended for them, bottles and breast milk should be labeled with the child's first and last name.

The following are general requirements for food storage:

- During storage, preparation, display, serving, or transportation, food should be protected at all times from potential contamination, including dust, insects, rodents, unclean equipment and utensils, unnecessary handling, coughs and sneezes, flooding, drainage, and overhead leakage or dripping from condensation.
- Containers of food should be stored a minimum of six inches above the floor in a manner that protects the food from splash and other contamination and that permits easy cleaning of the storage area.
- Containers for food storage other than the original container or package in which the food was obtained should be impervious and non-absorbent, have tight-fitting lids or covers, and be labeled as to contents.
- Food, whether raw or prepared, if removed from the container or package in which it was obtained, should be stored in a clean, covered container except during necessary periods of preparation or service.
- All fruits and vegetables should be washed thoroughly with water prior to use.
- Eggs should be well-cooked before being eaten, and only pasteurized eggs or egg substitutes should be used in foods requiring raw eggs.
- Food not subject to further washing or cooking before serving should be stored in a way that protects it against cross contamination from food requiring washing or cooking.
- Frozen foods should be kept frozen and must be stored at a temperature of zero degrees Fahrenheit or below.
- 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.
- 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.
- All opened perishable 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. This includes meat, poultry, or seafood or any perishable food that is subject to decay, spoilage, or bacteria unless it is properly refrigerated or frozen.
- Fully cooked and ready-to-serve hot foods should be held for no longer than 30 minutes before being served, or promptly covered and refrigerated.

The following are requirements for food safety:

- **Age-appropriate food:** Food served to children must be developmentally appropriate and safe based on each child's age and stage of development. Food must be provided to all children in care at appropriate meal and snack times consistent with their nutritional needs.
- **Safe food and drinking water:** Food served to children must be safe for consumption. Food must not be expired or moldy and must be properly stored, handled, and prepared in accordance with applicable food safety standards. Safe drinking water must be readily available to children.

- **Preventing contamination and choking hazards:** Appropriate measures must be taken to prevent cross-contamination of food, including avoiding exposure to known allergens for children in care. Foods that present a choking hazard must be modified as necessary to reduce the risk based on each child's age and developmental level.
- **Active supervision during meals and snacks:** Children must be actively supervised during meals and snacks. Providers must take appropriate precautions to reduce the risk of choking, allergic reactions, and other hazards related to food consumption.
- **Food-related emergencies:** Providers must respond appropriately and promptly to food-related emergencies, including choking, allergic reactions, and suspected foodborne illness. Providers must maintain current training or demonstrate competency in responding to these emergencies, including first aid and emergency response procedures, as applicable.

Indicators

☑ Check food and kitchen item storage areas for cleanliness (e.g., no evidence of insects and rodents, and check that refrigerators, freezers, pantries, and cabinets are free of food spills and splatters).

☑ Observe the storage of food and food containers to ensure these items are stored above the floor and on clean surfaces protected from splash and other contamination.

☑ Verify the appropriate temperatures in the refrigerator and freezer.

☑ Observe the amount of time between food preparation and service to children when possible.

Resources and Forms

Guidelines for Child Care Providers to Prepare and Feed Bottles to Infants – eXtension Alliance for Better Child Care were developed by the National Cooperative Extension System and include safe handling of infant bottles in child care and helping parents make infant feeding decisions.

The Extension Alliance for Better Child Care provides food safety guidelines on how to store, prepare, and serve meals in child care at https://childcare.extension.org/food-safety-guidelines-for-child-care-programs/.

Making Food Healthy and Safe for Children - National Training Institute for Child Care Health Consultants (yumpu.com) - see Chapters 2, 3, and 4 on food safety. It provides charts on how often to clean food service items, how long to keep foods safely in the refrigerator or freezer, and a food safety checklist.

Caring for Our Children Basics (CFOCB) outlines a set of voluntary, foundational health and safety standards for early care and education programs. https://childcareta.acf.hhs.gov/cfoc

Building and physical premises safety

ARSD 67:42:17:32

A. All walls, ceilings, floors, and equipment must be easily cleanable, kept clean, and in good repair. Food preparation areas including tables and countertops shall be in good repair, free of cracks, and made of smooth nonporous material.

B. Heating and cooling systems must maintain a temperature between sixty-five degrees Fahrenheit and seventy-five degrees Fahrenheit.

C. For a child care center and school-age program, all heating and cooling systems must be inspected annually, by a certified technician.

D. Food preparation areas, including tables and countertops, must be made of a smooth, nonporous material, kept clean and sanitized, be free of cracks, and be in good repair.

E. Center and school-age programs, in which more than twenty children are cared for, must provide a ventilation hood over all cooking areas. The hood must be appropriate for the type of appliance and intended use, as required in § 61:15:01:01.

Intent

The cleanliness and maintenance of walls, ceilings, floors, and equipment reduce the risk of infections, disease, and injuries. Cracked walls, ceilings, and floors cannot be kept clean and sanitary. Damaged floors, walls, or ceilings can expose underlying hazardous structural elements and materials. This is especially true for food service areas and equipment where cracks on a surface, plate, or utensil can hide food that can promote bacteria growth and contamination.

The program must be heated, cooled, and ventilated to keep the temperature comfortable and to prevent germs, odors, and fumes from collecting within the building. Proper venting of heating equipment can prevent accumulation of carbon monoxide gas inside a building. Carbon monoxide is a colorless, odorless, poisonous gas that can cause asphyxiation. Properly maintained stove vents and filters control odors, fire hazards, and fumes that can affect children and employees in the program.

Clarification

Walls, including doors, windows, skylights, and similar closures; ceilings; and floors must be maintained in good repair. The walls should be smooth, nonabsorbent, and easily cleanable. Concrete or pumice blocks used for interior wall construction in these locations should be finished and sealed to provide an easily cleanable surface.

Floors in food preparation, restroom, laundry, and storage areas have the potential of water overflow and should be constructed of smooth, durable material such as sealed concrete, terrazzo, ceramic tile, durable grades of linoleum or plastic, or tight wood impregnated with plastic and must be maintained in good repair. Carpet should not be used in these areas. Cracked or porous materials should be replaced because they can trap water or sewage where mold, bacteria, or odors can grow. If used, carpeting should be of closely woven construction, easily cleanable, and maintained in good repair. Frequent vacuuming reduces dust and mites to which children may be allergic. Bodily fluids and messy play such as painting, play dough, and sand play can lead to the need for carpets to be cleaned often. All floor coverings should be tight to reduce tripping hazards.

Temperatures for programs are to be maintained between 65°F and 75°F during operating hours.

Heating, ventilating, and cooling systems in child care and school-age programs must be inspected at least once a year by a person qualified with experience in heating and ventilation maintenance. Heating equipment is the second leading cause of ignition in fatal house fires, and heating equipment that is kept in good repair is less likely to cause fires. The technician should verify in writing that the equipment is properly installed, cleaned, and maintained to operate safely, efficiently, and effectively, and the documentation including the date should be kept on file at the program.

Ventilation is necessary for air circulation and children's health. Acceptable means of ventilation may include central heat/air, vent fans, ceiling fans, portable fans that are inaccessible to children, screened and operable windows, etc. Adequate ventilation should be maintained during any cleaning, sanitizing, or disinfecting procedure to prevent children and providers from inhaling potentially toxic fumes.

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, and be made of smooth, nonporous material that is kept clean and sanitized. Repairs with duct tape, package tapes, and other commonly used materials create surfaces that can trap materials.

A facility that provides care for more than 20 children must provide a ventilation hood over all cooking areas. A ventilation system collects fumes and vapors from the stove and prevents them from moving to areas where children are present. A ventilation hood should be constructed of metal, vented to the outside, and have a removable grease filter.

Indicators

- ☑ Observe the condition of all walls, ceilings, and floor surfaces throughout the program to check for cleanliness, tripping hazards, and any damage or disrepair.
- ☑ Check the center's thermostat(s), if possible, to ensure temperatures are between 65°F and 75°F.
- ☑ For centers and school-age programs, observe documentation of the annual heating and cooling inspection and confirm that any recommendations were followed.

- ☑ Check to ensure that heating and cooling equipment does not pose a risk to children.
- ☑ Verify that food preparation and service surfaces are in good repair, free of cracks, and made of smooth, nonporous material that is kept clean and sanitized.
- ☑ Verify that center and school-age programs with more than 20 children in care have an appropriate ventilation hood over all cooking areas.

Resources and Forms

See CFOC 4th ed. 5.2.1 Ventilation, Heating, Cooling, and Hot Water, p. 224 for more information on indoor temperature and humidity, access to fresh air, and heaters and fireplaces at CFOC4 pdf- FINAL.pdf (nrckids.org).

ARSD 67:42:17:37 - 39

F. Center and school age programs operating outside of a school building shall follow applicable construction and fire safety requirements as outlined in chapters 61:15:05 and 61:15:06. School-age programs operating in a school building shall follow applicable construction and fire safety requirements as outlined in chapters 61:15:01, 61:15:02, and 61:15.07.

G. The following must be inaccessible to a child:

1. Firearms;
2. Pellet guns, BB guns, and cap guns;
3. Matches and lighters;
4. Tobacco products;
5. Choking and strangulation hazards;
6. Items capable of being pulled or tipped onto a child;
7. A platform measuring more than thirty inches above ground level, unless surrounded by a railing that is at least thirty-six inches tall with no more than five inches between openings; and
8. Other hazardous conditions identified by the department.

H. The department may direct a provider to remove or correct a hazardous condition or circumstance not covered in this chapter, if the department considers the conditions or circumstances to have the potential to cause injury or illness to the children in care.

I. For center and school-age programs, unused electrical outlets must have a self-closing outlet cover or tamper resistant cover.

Intent

Building and fire codes and licensing rules are a form of consumer protection that decreases a child's exposure to risk of fire, unsafe buildings, disease, injury, etc. Having a safe environment allows providers to focus on educational experiences for children to learn and grow.

To keep children safe, providers must ensure that the program is free of hazards or that hazards are inaccessible to children. Because there will be other hazardous conditions not specifically listed in these rules, providers, parents, and licensing should be watchful for anything that has the potential to cause injury or illness to children in care.

Clarification

Programs must meet applicable construction and fire safety requirements. If operating outside of a school building, providers should review ARSD 61:15:05 and 61:15:06. School-age programs operating in a school building should refer to ARSD 61:15:01, 61:15:02 and 61:15.07. https://sdlegislature.gov/Rules/Administrative/61:15

Fire safety requirements for center and school-age programs include:

- Fire extinguishers serviced annually and documented;
- Fire alarm system inspected annually and documented;
- Sprinkler system, if present, inspected annually and documented;
- Locked doors that unlock automatically when the handle is turned, or the door is pushed from the inside. Deadbolts cannot be used on any doors unless opening the door handle automatically releases the deadbolt in one motion, similar to a hotel room;
- Locks requiring a passcode entry only used on the outside of the building unless there is verification that the exit doors unlock with the activation of the fire alarm system;
- All exits remain unblocked;
- All exits to the outside have lighted emergency exit signs above them;
- Smoke detectors and alarm systems in accordance with fire safety requirements;
- For programs licensed to serve 20 children or fewer, smoke detectors must be hardwired and interconnected;
- Smoke detectors should be tested annually and back up batteries replaced every six months;
- Residential smoke detectors in programs serving 20 or fewer children should be replaced every 10 years; and
- Carbon monoxide detectors are required if the provider has fuel-burning appliances.

Fuel-burning appliances that require a carbon monoxide detector are devices that utilize combustion fuel to produce heat for cooking, water heating, or room heating (i.e., stoves, ovens, clothes dryers, furnaces, water heaters, heaters, and fireplaces). The location of a carbon monoxide detector, if required, should be determined in accordance with the manufacturer's instructions. Combination smoke and carbon monoxide detectors are permitted and should be installed on the ceiling or high on the wall.

The program should be free of health and safety hazards to reduce risks to children as supervision alone cannot prevent all accidents and injuries.

If present, firearms including pellet guns and BB guns 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. Additionally, weapons such as darts, bows and arrows, cap pistols, stun guns, and paint ball guns should be inaccessible to children.

Items that present a choking hazard for children include coins, balloons, safety pins, marbles, Styrofoam© and similar products, plastic bags, and sponge, rubber, or soft plastic toys. Underinflated or uninflated balloons of all types could be chewed and pieces potentially aspirated. Eliminating small parts from children's play areas will greatly reduce the risk of injury and fatality from aspiration. According to the federal government's small parts standard on a safe-size toy for children under three years of age, a small part should be at least one and one-quarter inches in diameter and between one inch and two and one-quarter inches long. If an item can fit inside a paper towel roll, it could potentially be swallowed by a child under three years of age.

Strangulation is the leading cause of death for children under a year old and among the top five causes of death for children between the ages of one and four years. It is also the leading cause of death for playground fatalities. Some of these deaths occur when drawstrings on sweatshirts, coats, and other clothing get caught in gaps in the equipment. Attention should also be paid to items in the dramatic play area such as straps on bags, ties, scarves, necklaces, and boas if used for children under three years.

Infants are at greater risk of strangulation. Hazards include strings and cords (such as those that are parts of toys and those found on window coverings) long enough to encircle a child's neck. Miniblinds and venetian blinds should not have looped cords. Vertical blinds, continuous looped blinds, and drapery cords should have tension or tie-down devices to hold the cords tight. Since 1990, more than 200 infants and young children have died from unintentional strangulation in window cords. Pacifiers attached to strings or ribbons should not be placed around infants' necks or attached to infants' clothing as they may become tightly twisted or can catch on crib corner posts, causing strangulation. Crib gyms pose a potential strangulation hazard for infants who can lift their head above the crib surface.

Accordion gates with large V-shaped openings along the top edge and diamond shaped openings between the slats present entrapment and entanglement hazards resulting in strangulation, choking, or pinching to infants who try to crawl through or over the gate. If baby gates are used, the following must be met:

- Minimum gate clear width opening of 32 inches if used in a doorway.
- Must swing in the direction of egress travel.
- Must be able to be opened without any special knowledge and should either open in one motion or be openable by using one hand.
- Gates cannot be used on exit doors, corridors, or hallways that could impede exiting the building.

Providers should check potentially unstable equipment and furniture (e.g., aquariums, televisions, bookcases) to ensure the items have been secured. Equipment and furniture should be secured if the weight or size could injure a child if it fell over. From 2000 through 2006, the CPSC reported 134 tip-over related deaths involving children five years old or younger. As televisions have increased in size, they have proven to be more deadly, associated with more than half (62%) of reported fatalities.

To help prevent tip-over hazards, CPSC recommends verifying that furniture is stable on its own, but for added security, entertainment units, TV stands, bookcases, shelving, and bureaus can be anchored to the floor or attached to the wall all using appropriate hardware, such as brackets, screws, or toggle bolts. One way to make furniture moveable and to minimize tipping hazards is to add a wider or low-rise base.

A railing is required if a platform accessible to children is more than 30 inches above ground level. This includes open-sided stairs, decks, and play equipment. The railing or barrier should be constructed to prevent a child from crawling or falling through or becoming entrapped and be at least 36 inches high. The spindles or balusters may have no more than five inches between any open spaces on the railing, and less depending on the age of children in care.

There may be additional hazardous conditions that need to be corrected if they have the potential to cause injury or illness to the children in care. Examples include sharp scissors, plastic bags, toxic plants, knives, batteries, magnets, and other items labeled “keep out of the reach of children.” Cords for phones or other electronic devices should not be hanging down where children can reach them, and electrical items must be kept away from water as well as inaccessible to children. Providers may wish to check on a regular basis to ensure that toys and equipment have not been recalled by the CPSC. Providers should look for and act on potential hazards both indoors and outdoors such as holes in the mesh of port-a-cribs, broken toys with rough edges that could cut children, or cracks in toys that could pinch children.

Providers must ensure that all foods served to children are developmentally appropriate and safe based on each child’s age and stage of development. Foods that pose a choking risk must be modified as needed, such as cutting foods into small, manageable pieces and avoiding items that are not suitable for young children. Providers are responsible for actively supervising children during meals and snacks and taking appropriate precautions to reduce the risk of choking or other hazardous conditions.

Electrical outlets are most often found at a toddler’s level and therefore can be very enticing. Approximately 2,400 children are injured annually by inserting objects into the slots of electrical outlets. Outlet covers at least deter children from placing objects into exposed outlets that could cause electrical shock, electrical burns, and potential fires. Center and school age care programs must have self-closing or tamper-resistant outlet covers that cover outlet holes automatically upon removal of appliance prongs, including GFCI outlets. Unused outlets in a power strip must also have safety covers or can be locked if the power strip is located where children can reach it.

Heating and cooling equipment can be hazardous to children resulting in burns, electric shock, entanglement in the rotary blades of a fan, etc. Heating and cooling units that are located in a part of the building that is accessible to children should be enclosed by a closet or barrier such as guards, protective screens, or other devices. This includes hot water heating pipes and baseboard heaters with a surface temperature hotter than 120°F. Approved space heaters should have a protective covering that prevents children from tampering with the heating elements. Fans must be placed so they are inaccessible to children and portable fans, if used, must be guarded to limit the size of the opening in the blade guard to less than one-quarter inch.

In accordance with state law (SL 2009, ch 171, § 4, §§ 34-46-14 - 34-46-15), smoking is prohibited on the premises of center and school-age programs.

Indicators

- ☑ Check program or licensing files for current documentation of compliance with all applicable construction and fire safety requirements.
- ☑ Check all indoor and outdoor spaces for existing or potential hazards.

☑ Ask to see where and how firearms are stored to verify safety measures.

Resources and Forms

The Health and Safety in Child Care website provides tips for keeping children healthy and safe including information on toy and equipment safety at Health and Safety in Child Care – eXtension Alliance for Better Child Care.

Information about securing equipment and furniture to prevent tip-over accidents is on the CPSC website at https://www.cpsc.gov/Safety-Education/Safety-Education-Centers/Tipover-Information-Center.

Search for recall information on furniture, materials, and toys, and sign up for product recall notifications at https://www.cpsc.gov/Recalls.

Caring for Our Children Basics (CFOCB) outlines a set of voluntary, foundational health and safety standards for early care and education programs. https://childcareta.acf.hhs.gov/cfoc

ARSD 67:42:17:33

J. A provider shall meet the following requirements regarding bathrooms:

1. Bathroom facilities must be easily accessible by children and providers;
2. Hot water for faucets normally used by children in care may not exceed one hundred twenty degrees Fahrenheit;
3. Toilets and hand sinks must be kept clean and in good repair;
4. For child care centers and school age programs:
   - **a.** All bathrooms must have natural or mechanical ventilation;
   - **b.** Separate bathrooms must be available for males and females;
   - **c.** Ratios for toilets and hand sinks must align with the minimum standards for plumbing and plumbing systems published by the plumbing commission.

K. Hand sinks must be in the same room, or an unobstructed room adjacent to the diaper changing area. A handwashing sink used after diapering and toileting may not be used for food preparation.

Intent

Young children use the toilet frequently and cannot wait long periods if a restroom is occupied or not easily accessible. Access to sinks for handwashing promotes cleanliness and prevents the spread of disease. Easy and safe access to toileting and handwashing facilities located in or near child care areas also help facilitate supervision. The toilet and hand sink to child ratio supports access and helps alleviate too much waiting.

Handwashing is essential in preventing the transmission of many communicable diseases. Warm water encourages longer handwashing, but hot water can injure children. Water heated over 130°F takes only 30 seconds to burn the skin. If the water is heated to 120°F, it takes two minutes to burn the skin. That extra time could provide enough time to remove the child from the hot water source and avoid a burn.

Regular and thorough cleaning of bathrooms, adequate ventilation, and separate food preparation sinks help prevent the transmission of disease and odors.

Bathrooms for males and females provide privacy for those who prefer separate bathrooms.

Clarification

Sinks for the diaper changing area must be in the same room or non-obstructed adjacent room. An adjacent room should not have a closed door or gate that could allow transfer of contaminants to other surfaces enroute to handwashing. Permanently plumbed handwashing sinks with running water are required for all designated handwashing areas.

Water temperature should be monitored with a thermometer and adjusted to ensure it will not injure children. Scald-prevention devices can also be used to assist in maintaining a proper temperature.

One of the most important steps in reducing the number of germs and spread of disease is the thorough cleaning and disinfecting of surfaces. Bathroom surfaces (i.e., faucet handles, toilets, sinks, floors) should be cleaned and disinfected at least once a day and when soiled.

Natural ventilation can come from an open screened window, but in recognition of weather variations, a functioning exhaust fan and duct system is preferable.

Bathrooms for preschool children can be used by both genders; however, there must be bathrooms in the building that are designated as male and female.

The current ratio for toilets to hand sinks is 15:1, and changes by the Plumbing Commission are not anticipated. Urinals will count in the toilet/hand sink ratio if there is a toilet in the bathroom and the number of urinals does not exceed the number of toilets in a bathroom. The Plumbing Commission's requirements are available at 605-773-3429. Potty chairs for toilet training do not count as toilets in the toilet/child ratio.

A supply of soap, toilet tissue, hand towels, and easily cleanable waste receptacles should be provided in each bathroom at all times. When supplies are lacking or out of reach, it discourages children from practicing proper handwashing and toileting techniques.

Learning to use the toilet and to practice proper handwashing are important self-help skills for children. To provide for easier use and to permit children to use the fixtures on their own, you may consider having toilets and sinks be child-height or equipped with safe, cleanable, and stable steps or broad-based platforms. This helps children develop competency and self-esteem and increases bathroom safety.

It is important to have separate sinks for handwashing after diapering and toileting and for food preparation to reduce the risk of contamination. This includes washing food service items and bottles.

Indicators

- ☑ Confirm that the required number of toilets and sinks are easily accessible.
- ☑ Verify that hand sinks are located in the same room or non-obstructed adjacent room as the diaper changing area and are not used for food preparation.
- ☑ Routinely monitor water temperatures in sinks used by children to ensure that children cannot be burned.
- ☑ Verify hot water temperature at handwashing sinks does not exceed 120°F.
- ☑ Observe bathrooms to ensure they are in good repair, clean, and free from odors. If concerned with cleanliness, ask providers about cleaning procedures for the bathroom areas (i.e., when cleaned, how often, type of product used).
- ☑ Confirm adequate ventilation through the use of operable screened windows or vented exhaust fans.
- ☑ Observe that there are separate bathrooms for each gender within the building

Resources and Forms

This summary addresses the importance of supervision in bathrooms and reviews safety risks: Bathroom Safety in Child Care – eXtension Alliance for Better Child Care.

ARSD 67:42:17:35

L. Playgrounds for all child care settings must be safe, in good repair and free of debris, trash, and weeds.

1. Playground equipment must be installed according to the manufacturer's instructions and maintained in good repair.
2. For a center program, a fence that measures at least four feet high is required around the center's outdoor play space.
3. For school age programs, a fence that measures at least forty-two inches high may be required to separate the outdoor play space, if the department determines a body of water, vehicular traffic, or other hazard poses a risk of injury or death to a child.
4. Playgrounds and parks may be used for outdoor play.

Intent

Playing outside is healthy for children. Having safe and enriching outdoor environments encourages exercise that promotes well-being and physical development. Children are naturally drawn to active play outdoors. It allows them to explore their environment, develop muscle strength and coordination, and gain self-confidence. It also provides them with vitamin D, reduces stress, increases attention span, and reduces obesity.

Providing a playground that is safe, well-maintained, and fenced when needed allows providers to focus on children's activities. Each year, approximately 200,000 children are treated in U.S. hospital emergency rooms for playground equipment-related injuries. Studies have linked inadequate maintenance of equipment to injuries on playgrounds. Providers are better able to supervise activities when children are in a fenced area that prevents access to streets, parking lots, water areas, etc.

Clarification

Playground equipment must be properly installed according to the manufacturer's instructions and maintained in good repair. Equipment should be arranged so that providers have clear lines of sight to children playing on equipment. All openings in pieces of play equipment should be too large for a child's head to get stuck or too small for a child's body to fit in to prevent entrapment and

strangulation. Playground equipment should be routinely inspected to ensure the structures are in good repair.

Children should have access to a variety of outdoor play experiences that meet the needs of each age group and provide opportunities for individual choice and cooperative play. Outdoor play equipment should be of a size and skill level that is appropriate for the ages and developmental abilities of the children who use it. Children need equipment for climbing, balancing, riding, building, pushing, pulling, lifting, digging, running, etc. Enough play equipment and materials should be available to avoid excessive competition and long waits. Sandboxes may need to be covered to keep out animal feces, insects, mold, and bacteria. Trampolines should have a safety net enclosure and be in good repair.

Climbing and swinging equipment should be securely anchored to prevent tipping. Some smaller, stable, portable equipment for younger children may not require anchoring. All bolts, screws, or concrete used to secure or anchor equipment should be covered.

CPSC and ASTM International (ASTM) have issued recommendations for public playground equipment. Certified Playground Safety Inspectors certified by the National Recreation and Park Association may be available to conduct an inspection of playground plans for new installations or inspect existing playgrounds.

Centers are required to have a fence that is at least four feet in height that prevents children from getting over, under, or through it and keeps them from leaving the outdoor play area. Although fences are not childproof, they provide a layer of protection for children from stray animals and other potential hazards. Fencing used to separate two play areas is not required to meet the four-foot height minimum. Fences should be maintained in good condition with no gaps, loose wires, exposed sharp prongs, bolts extending more than two threads, etc. Programs should consider selecting a fence design that prevents the ability to climb on either side of the fence. To ensure the safety of children in emergency situations, there should be two separate exits from the fenced area. One exit can go directly into the building, and the second exit could be a gate that allows evacuation from the fenced area away from the building. The fenced area does not have to be directly connected to the building but must be safely accessible.

School-age programs may be required to have a fenced play area if a body of water, vehicular traffic, or other hazard poses the risk of injury or death to a child.

Nearby playgrounds and parks may be used for outdoor play. If leaving the center premises, providers should be prepared to address how children will safely access the outside play area, any hazardous conditions, how toileting needs will be met, and how children have access to materials, equipment, and opportunities to explore and play during outside time.

Providers may wish to consider the use of impact-absorbing material to reduce risk to children on playgrounds. Over 70% of all accidents on playgrounds are from children falling. A fall onto an impact-absorbing surface is less likely to cause a serious injury because the surface is yielding. Dirt is not considered impact absorbing material, and grass is acceptable only when the fall height is four feet or less. Equipment used for climbing and swinging should not be placed over or immediately next to hard surfaces such as asphalt, concrete, dirt, or grass. Examples of loose fill materials include sand, pea gravel, wood chips, wood mulch, and shredded rubber. Since the shock absorbing capability of loose fill materials decreases with repeated impact, continuous care is necessary to maintain the cushioning effect.

Exposure to the sun is good for children, but they should be protected from excessive exposure. People who suffer severe childhood sunburns are at increased risk for skin cancer. Shading may be provided by trees, buildings, or shade structures. Metal equipment, especially slides, should be placed in the shade.

Indicators

- ☑ Check the outdoor play area and equipment for hazards, debris, trash, and weeds.
- ☑ Observe outdoor play equipment to ensure the equipment is appropriate for the ages and abilities of the children and meets manufacturers' guidelines (i.e., construction, installation, and use).
- ☑ Confirm that a center's fence is four feet high, sturdy, solid, and maintained to prevent children from leaving the playground area.
- ☑ Confirm that there are no hazards that would require a school-age program playground to be fenced.
- ☑ Observe any fence gates on the playground to ensure the gates are kept closed whenever children are present.

Resources and Forms

The *Public Playground Safety Handbook* from the CPSC addresses selecting equipment, surfacing, playground hazards, and maintenance, and includes suggested general maintenance checklists at Public Playground Safety (cpsc.gov).

This one-hour webinar identifies the most common risks for outdoor injuries as well as strategies to help programs create safer playgrounds: Playgrounds! Promote Safe and Fun Outdoor Play in Head Start and Child Care | ECLKC (hhs.gov).

The Health and Safety in Child Care website provides tips for keeping children healthy and safe including information on playground safety at Health and Safety in Child Care – eXtension Alliance for Better Child Care.

ARSD 67:42:17:36

M. A provider shall meet the following water safety requirements:

1. If an outdoor swimming pool is on premises, it must be emptied after each use or enclosed with a five-foot fence and a self-closing, latching gate that can be locked while not in use;
2. If an indoor swimming pool is on the premises, it must have an access door that restricts entry;
3. A child may not play in an area where there is a body of water, unless the provider can see and hear the child, and is close enough to intervene, at all times; and
4. A hot tub must be securely covered.

Intent

Any body of water, including wading pools, swimming pools, and hot tubs, presents a drowning risk to young children. Drowning is one of the leading causes of unintended injury to children under five years of age. Installing fencing around any swimming pool that is not emptied after each use and covering hot tubs will reduce the risk of drowning or other water-related injuries.

Clarification

If left unattended with water, a wading pool poses a drowning risk to children. If used, wading pools must be emptied each day. Because they have no filtering system and can promote the transmission of infectious diseases, it is also recommended that they be cleaned, sanitized, and allowed to dry in the sun for at least four hours. Wading pools should also be stored inverted so that they do not hold water.

Both inground and aboveground outdoor swimming pools on the premises must be enclosed with a five-foot fence that is constructed to discourage climbing and kept in good repair. The building's exterior wall can count as one side of a fence if the wall has no openings (e.g., doors, windows) that provide direct access to the pool. Aboveground pools should have non-climbable sidewalls and steps removed when the pool is not in use. Exits from and entrances to the pool must have self-closing, latching gates that must be latched and always locked when children are present. Latches should be a minimum of 55 inches from the ground. Providers should be alert to any indoor or outdoor furniture and equipment that a child could use to climb over a fence or release a lock.

Indoor swimming pools must have restricted access for children with a locked door that prevents children from accessing the pool without an adult.

To protect children from water-related accidents, children must not be permitted to play or swim without constant supervision in areas where there is any body of water including pools, swimming pools, wading pools, ditches, fishponds, and water retention or detention basins.

It is recommended that if children are allowed to swim in a pool, providers should ensure that safety measures such as life-saving devices and drain grates are in place and not removable without using tools, and that water quality is monitored.

Indicators

- ☑ If wading pools are used, discuss the program's practices for emptying the pool.
- ☑ If there is an outdoor swimming pool on the premises, check to ensure the pool is completely enclosed by a fence that measures at least five feet in height and discourages climbing.
- ☑ Confirm that gates have self-closing and latching gates and that they are locked when not in use.
- ☑ If there is an indoor swimming pool on the premises, confirm that there is an access door that restricts entry.

☑ If there is a hot tub on the premises, verify that it has a secure cover that prevents children's access.

Resources and Forms

The American Academy of Pediatrics provides pool safety guidelines for parents including fencing and pool covers that are also useful for providers at Pool Dangers and Drowning Prevention—When It's Not Swimming Time - HealthyChildren.org.

ARSD 67:42:17:34

N. A center program must have available a minimum of thirty-five square feet of play space indoors and fifty square feet of play space outdoors for each child. A school-age program must have a minimum of twenty-five square feet of play space indoors and fifty square feet of play space outdoors for each child. Playgrounds and parks may be used for outdoor play space.

Intent

Young children relate to the world through their bodies and their senses, and they require space in which to learn by moving and doing. Having sufficient space for children to freely move, explore, and develop large muscle skills helps reduce conflict, the spread of infection, and the risk of collisions and other injuries.

Clarifications

There must be at least 35 square feet of play space indoors for each child. The only space counted is the primary play space that children play in throughout the day. Floor space used for permanent and stationery equipment and furniture, storage, halls, bathrooms, offices, special-use areas like a gym or cafeteria, and kitchens may not be included in the determination of usable play space for children. The indoor space required for a school-age care program is 25 square feet per child as children of school age are not generally as active during indoor play as younger children. The overall room capacity and individual room capacity can be found on the program's health and safety review letter.

The following process is used to calculate indoor square footage:

- Divide the usable floor space by 35 square feet to obtain the licensed capacity of each room or area that children play in throughout the day.
- To express the figure as a whole number, decimals of 0.50 and above should be rounded up, and those of 0.49 and below should be rounded down.
- Add the capacity of each child care room or area together to obtain the total licensed capacity for the center.

The program must provide a minimum of 50 square feet of outdoor play space for each child on the playground at any one time. Areas that protrude into the space, such as fenced enclosures around a heating and air conditioning unit, are not counted when determining the capacity of the outdoor play space. An outdoor play schedule can ensure that all children can play outside while not exceeding the number of children that can play outside at any one time.

If the center or school-age program does not have an on-site outdoor play area and uses a park for outdoor play, the park area is not measured for square footage.

Indicators

- ☑ Observe the number of children present in each classroom and check against the assigned capacity determined by the health and safety review for that classroom.
- ☑ Observe the total number of children present in the center and check against the program's total licensed capacity determined by the health and safety review.
- ☑ When possible, observe the number of children present on playgrounds and check against the capacity determined by the health and safety review for each playground.
- ☑ Ask about the scheduled use of playground areas and verify that the playground's capacity is not exceeded throughout the day.

Resources and Forms

DSS Floorplan Review Guide - https://dss.sd.gov/formsandpubs/docs/CCS/OLA-116_Floor_Plan_Review_Guide.pdf.

ARSD 67:42:17:40

O. A pet, while permitted in the presence of children receiving care, must be current with its vaccinations, and have clean and sanitary living areas, at all times.

P. A pet with a history of aggressive behavior, which poses a risk to the safety of children, must be confined and kept away from children.

Intent

Animals may be a valuable and effective teaching aid for children, but the program must be sure that animals are healthy and suitable before bringing them into contact with children. The risk of injury, infection, disease, and aggravation of allergy from contact between children and animals is significant.

Clarification

If a pet is present on the child care premises, the pet must have current vaccination records, even if the pet does not have access to or interact with children in care. Dogs and cats must be vaccinated

for any disease that can be transmitted to humans, and there must be documentation that the animal has had the required vaccinations and that they are current.

Animals should demonstrate a calm, friendly demeanor toward children and people that they don't know and should not have any history of aggression. Animals with a history of aggression need to be confined and kept away from children. Some children in care may not have pets at home and may not understand that pulling the dog's tail or ears hurts them. The added attention from many children may irritate the pet, causing uncharacteristic reactions to the children. Providers must remain close enough to remove the child immediately if the animal shows signs of distress (e.g., growling, barking, baring teeth, tail down, ears back) or the child shows signs of fear, or if there is a threat of the child treating the animal inappropriately. Appropriate pens or kennels will aid in the prevention of harm to children and the escape of the animal.

It is recommended that the following animals not be permitted around children:

- Wild or dangerous animals such as ferrets, bats, and monkeys;
- Lizards, hermit crabs, turtles, and other reptiles (they may be kept in a covered glass container or tank that is inaccessible to children);
- Potentially aggressive animals such as pit bulls, rottweilers, wolfdog hybrids;
- Stray or young animals because of issues regarding unpredictable behavior and elimination control;
- Parrots and other exotic birds; and
- Chickens or ducks.

Keeping animals' living areas clean includes their food, waste, and debris being inaccessible to children and reduces the chance of disease in the animal or in humans. Litter boxes must be inaccessible to children, covered, and kept clean to eliminate odors.

Informing parents in writing when animals are or will be present at the program allows parents to decide whether to enroll their child and whether to prohibit or allow their child to have contact with the animals.

Many human illnesses can be acquired from animals. Additional recommendations for reducing the risk of disease transmission are:

- Ensure that children do not handle any animal that shows signs of illness, such as lethargy or diarrhea.
- Keep animals away from places where food is prepared, stored, or eaten such as tables and counters.
- Do not clean animal habitat or equipment where food is prepared, stored, or eaten.
- Ensure that caregivers and children wash their hands after handling an animal, cleaning the cage, or caring for the animal in any way.
- Treat animals as needed for fleas, ticks, and worms.

Research has shown there is a high risk of contracting and spreading salmonellosis by either direct contact or indirect contact with chickens, ducks, and reptiles such as snakes, turtles, lizards, iguanas, frogs, and toads. Salmonella is a type of bacteria that can cause vomiting, diarrhea, and abdominal pain. Children under five, pregnant women, the elderly, and people with weakened immune systems have a higher risk of getting salmonellosis and are more likely to have severe symptoms.

Indicators

- ☑ Review documentation of current vaccinations for all animals for which vaccinations are required.
- ☑ Observe any animals, animal pens, and confinement areas on the premises and related conditions (e.g., cleanliness, the animal's behavior, access) that could pose a risk to children's health and safety

Resources and Forms

The CDC's summary on Animals in Schools and Daycares provides recommendations for reducing the risk of animals spreading germs at https://www.cdc.gov/healthy-pets/schools-daycares/?CDC_AAref_Val=https://www.cdc.gov/healthypets/specific-groups/schools.html.

Choosing, Introducing, and Caring for Pets in Child Care – eXtension Alliance for Better Child Care offers precautions for having pets in child care.

Prevention of child maltreatment

ARSD 67:42:17:41

A. A provider shall meet the physical, social, emotional, and cognitive needs of a child, and identify procedures to implement behavior management strategies for use with children in care. Behavior management strategies must offer limits, with positive guidance and direction, to help a child develop self-control and respect for the rights of others, be appropriate to a child's age and developmental level, and include strategies to prevent shaken baby syndrome and abusive head trauma.

B. A behavior management strategy may not be delegated to an older child or peer.

C. Separation, when used as a strategy, must be within sight or hearing of a provider.

D. The parent of a child may not, while working at the program, use a prohibited discipline technique to discipline the parent's child.

E. The following methods of discipline are prohibited:

1. Spanking, hitting, pinching, biting, shaking, or inflicting any other physical punishment;
2. Verbal abuse, shouting, threats, humiliation, or derogatory or sarcastic remarks about the child or the child's family;
3. Restriction of movement or confinement;
4. Isolating a child in an adjacent room, hallway, closet, darkened area, or any other area where a child cannot be seen or supervised;
5. Punishment for lapses in toilet training;
6. Withholding or forcing of meals, snacks, naps, or outdoor time to correct behavior;
7. Demanding excessive physical exercise or excessive rest; and
8. Placing substances in a child's mouth to cause discomfort such as soap, food, or spices.

F. A provider who is under investigation for abuse and neglect may not be in a caregiving role if the department determines there is an imminent safety concern to a child in the provider's care.

Intent

Behavior management 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. When a child needs assistance to resolve a conflict, manage a transition, engage in a challenging situation, or express feelings, needs, and wants, the provider must be able to help the child learn strategies for dealing with the situation 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.

Non-punitive disciplinary practices enable a child to develop self-control and do not result in physical or emotional damage to the child. Harsh or abusive language can cause fear and anxiety in children and seriously damage a child's self-esteem. Even mild shaking of a young child can result in serious, permanent brain damage or death.

Clarification

Discipline means to teach and to guide and should involve learning and education. Providers should rely on positive guidance for managing children's behavior, a technique that teaches the child what is expected to establish self-control rather than punishing them for what they did. Positive guidance techniques include setting clear limits, redirection, anticipation and elimination of potential problems, positive reinforcement, and encouragement rather than competition, comparison, and criticism. Providers should offer children positive alternatives rather than just telling children "no."

Other positive guidance strategies include:

- Monitoring children's negative behaviors such as tattling, bossing, and bullying to prevent these behaviors from escalating into children mistreating other children.
- Encouraging children to use their words when expressing their feelings to others instead of acting them out.
- Embedding activities into group time or circle time that teach children conflict resolution skills such as sharing, taking turns, requesting a toy, and joining play with other children. Providers can use role play and/or puppet play to help children learn and practice these skills.

Providers should use discipline methods that are appropriate to the child's age and developmental level. Expectations of children's behavior, self-control, and personal skills increase with age but still vary based on each child's temperament and background. Directions and limits should be clear and appropriate to the child's level of understanding.

Separating children from the group, often called time-out, can provide time for the child to regain control of themselves. Providers must not isolate a child in an area where they cannot be seen and supervised. Monitoring a child's response to isolation is critical as they may be angry or upset and need reassurance. The provider should consider the child's age, developmental stage, tolerances, and ability to learn from time-out. Children under the age of three are too young to understand the consequence of being separated from an activity. Time-out should be used for very short periods of time, usually one minute per year of the child's age. Providers should end the time-out on a positive note and allow the child to feel good again. Discussions with the child to "explain WHY you were in time-out" are not usually effective.

Asking children of any age to implement behavior management strategies for another child is not appropriate and can be upsetting or disturbing to both children. Providers should never encourage a child to belittle or physically retaliate against another child (e.g., by biting back, by hitting back), which can promote bullying behavior. Providers should encourage children to treat each other with respect by modeling this behavior for them.

A provider should not be allowed or encouraged to use a prohibited discipline technique even if it's for their own child. This could be humiliating for the child and distressing to other children in care.

Child development research supports that physical punishment such as pinching, shaking, or hitting children or placing substances in a child's mouth to cause discomfort teaches them that hitting or hurting others is an acceptable way to control unwanted behavior or get what they want. Children will also mimic adults who demonstrate loud or violent behavior. Non-punitive methods of controlling behavior, such as diversion, separating children, and rational explanations of expectations are more effective than the use of physical punishment, criticism, or other types of humiliating or abusive techniques. Permission or instruction by parents to use punitive measures does not relieve providers from adhering to the rule.

Verbal abuse can occur in many forms. A child may feel humiliated if providers do or say something that results in the child feeling ashamed, foolish, or embarrassed. Humiliation often results from being publicly disciplined. A young child may feel fear and anxiety and learn to associate their providers and classrooms with frightening experiences. Examples of verbal abuse include threatening to call a child's parent or the police, speaking directly to a child in a loud and threatening voice, or making derogatory or sarcastic remarks about the child or their family. Shouting to be heard by children is not prohibited unless it is harsh, threatening, or upsetting to a child.

If restriction of movement is necessary for their own or other's protection, a child may be held as gently as possible and for no longer than necessary for them to regain self-control. Examples of inappropriate restraint include but are not limited to holding a child with undue physical force, holding a child down on a sleep surface, etc. Mechanical and physical restraints may physically and emotionally harm a child and do not teach children positive behavioral alternatives. Providers should never withhold active play from a child who misbehaves (i.e., keeping a child indoors with another caregiver while the rest of the children go outside or making a child sit out of active play in the afternoon for a behavior that occurred in the morning).

Children should not be punished for lapses in toilet learning. Even older children may lack physical control or be in situations where they must wait to go to the bathroom. Making a child clean up their own toileting accident is considered punishment and is prohibited by the rule.

Providers should not use food, naps, exercise, or outdoor time to correct behavior as these are positive and necessary needs of children and should not be associated with discipline. Providers should never force-feed a child as it can result in choking, injury, or emotional trauma.

It is important for children to develop lifelong healthy eating habits such as eating if they are hungry, and stopping when they are full. Using food as a reward encourages "non-hungry" eating and can lead to children over-eating and can affect their natural ability to regulate their appetite. If food is used as a bribe or reward or to induce happiness, eating may become associated with positive feelings of accomplishment or feeling happy. This may increase the risk of a poor relationship with food and emotional eating later in life.

It is recommended that each program have a written policy outlining behavior management techniques to be utilized with children in care that can be shared with providers and parents.

Expulsion of children from a program denies the child the benefit of continuity of quality child care and may prevent them from receiving potentially beneficial mental health services. Children may also develop negative views about learning, school, teachers, and the world around them. 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. The ECE program offers technical assistance and coaching on the prevention of suspension and expulsion in early childhood programs. It is an expectation that child care providers seek training, technical assistance, and support to determine a positive approach that allows a child with challenging behaviors to remain in care, or if necessary, move on to a more appropriate setting. It is recommended that each program have a written policy outlining expulsion (termination of care) policies.

All programs caring for infants may have written procedures to identify and prevent shaken baby syndrome and abusive head trauma. This includes training on recognizing potential signs and symptoms; creating strategies for coping with a crying, fussing, or distraught child; and understanding the development and vulnerabilities of the brain in infancy and early childhood. Victims of shaken baby syndrome and abusive head trauma may exhibit one or more of the following symptoms: irritability, trouble staying awake, trouble breathing, vomiting, and inability to be woken up.

When a complaint is received by Child Care Licensing, it is typically addressed through an unannounced on-site visit conducted by a Child Care Licensing Specialist. During the visit, the specialist gathers information, reviews records, and determines whether the program is in compliance with child care licensing rules.

If the concerns involve potential child abuse or neglect, the report may be investigated by Child Protection Services (CPS) or local law enforcement. In these situations, CPS and/or law enforcement serve as the lead investigating agency. CPS investigates allegations of child abuse or neglect, while law enforcement investigates potential criminal actions.

The Office of Licensing and Accreditation (OLA) is generally not directly involved in conducting abuse or neglect investigations; however, OLA maintains communication with the investigating agencies throughout the process. Depending on the circumstances, law enforcement or OLA may suspend a license to operate.

Providers must notify OLA within 24 hours if CPS or law enforcement initiates an investigation involving the provider or a program employee.

During an investigation into possible abuse or neglect by a provider, the department may determine that there are imminent safety concerns and prohibit the provider from having contact with children during the investigation. This action may help protect children in care and the provider from additional allegations until the investigation is complete and findings are determined.

Once the investigation conducted by CPS or law enforcement is completed, the licensing specialist will conduct a follow-up visit to determine whether any non-compliance with child care licensing rules occurred and whether corrective action is required.

Child care programs are required to cooperate with investigations conducted by OLA, CPS, or law enforcement. During an investigation, providers must allow timely access to staff for private interviews, records, areas of the program relevant to the investigation, and other documentation

requested by the investigating agency. Licensing specialists will conduct staff interviews without the presence of program leadership to allow staff to provide information freely and to support an objective investigation. Program leadership will be interviewed separately and will have an opportunity to provide information and respond to concerns.

If a program has video surveillance, the program must provide requested footage to OLA or another authorized investigating agency, such as CPS or law enforcement. Programs must take reasonable steps to preserve relevant video footage and prevent it from being deleted or overwritten once they are aware it may be needed for an investigation. Failure to provide requested records or video footage, or actions that interfere with an investigation, may be considered a failure to cooperate and may result in licensing action as authorized by state law.

Programs are encouraged to have a written policy outlining how suspected in-house allegations of abuse or neglect involving a provider or program employee will be handled. The policy should acknowledge that temporary removal or suspension from duties may occur if the Department of Social Services determines that the safety of children in care may be at risk.

Indicators

- ☑ Observe provider-child interactions in each classroom to determine if providers are using positive guidance techniques.
- ☑ Ask providers in each classroom how they handle children's behavior issues if behavior management strategies are not observed.
- ☑ Observe children's behaviors and notice any extremes such as aggressiveness, withdrawal, fear of providers, etc.
- ☑ If time-out is being used, observe the length of time children are required to remain separated, the location to be used for time-out, and that children are supervised.
- ☑ Observe children's interactions with each other. If a child attempts to discipline or humiliate others, observe whether providers intervene to alleviate the problem or ask how they would handle those situations.
- ☑ Observe provider-child interactions for evidence of any inappropriate discipline practices such as the tone of voice used by providers to communicate with children.
- ☑ Ask providers how they handle toileting accidents and children who will not eat during mealtimes and who will not rest during nap times.
- ☑ Review program's strategies on preventing shaken baby syndrome and abusive head trauma.
- ☑ Ask infant and toddler providers how they cope with crying babies and if assistance is available if needed. If concerned, ask them if they are aware of the symptoms and risks of shaken baby syndrome and abusive head trauma.
- ☑ Review program's policy on behavior management techniques if available.
- ☑ Re view program's written policy on expulsion if available.

Resources and Forms

This website provides a series of articles on preventing and responding to common behavior problems in a child care setting including biting. https://childcare.extension.org/basic-tips-child-care-providers-can-use-to-guide-childrens-behavior/.

An article by Zero to Three offers suggestions for responding to toddlers who do not understand logic and have a hard time with waiting and self-control. https://www.zerotothree.org/resource/toddlers-and-challenging-behavior-why-they-do-it-and-how-to-respond/.

For more information and resources on shaken baby syndrome and abusive head trauma, contact the National Center on Shaken Baby Syndrome at www.dontshake.org.

CFOC 4th ed. Standard 2.2.0.8 - Preventing Expulsions, Suspensions, and Other Limitations in Services provides alternatives to expulsion for children exhibiting extreme levels of challenging behaviors. https://nrckids.org/CFOC/Database/2.2.0.8.

The National Center on Afterschool and Summer Enrichment has helpful resources including helping school-age children overcome Adverse Childhood Experiences (ACEs), strengthening the child care workforce, and business practice tips. https://childcareta.acf.hhs.gov/center/national-center-afterschool-and-summer-enrichment.

Caring for Our Children Basics (CFOCB) outlines a set of voluntary, foundational health and safety standards for early care and education programs. https://childcareta.acf.hhs.gov/cfoc.

South Dakota ECE Shared Resources - https://sdece.org/resources/.

Emergency preparedness and response planning

ASRD 67:42:17:43

A. A provider shall have:

1. A written emergency preparedness and response plan for emergencies resulting from a natural disaster or a man-caused event;
2. A written plan for evacuation, relocation, shelter-in-place, or a lock-down, that includes accommodations for infants, toddlers, and children with disabilities or medical conditions;
3. A written procedure for communication and reunification with parents; and
4. A written procedure for the continuity of operations.

B. A provider shall practice the evacuation, shelter-in-place, and lock down procedures, outlined in the emergency preparedness and response plan, at least twice each calendar year. The provider shall document the dates on which the procedures are practiced.

C. A provider shall communicate the emergency preparedness and response plan to each individual at the time the individual begins employment.

D. Child care providers shall have liability insurance. Proof of current liability insurance shall be made available to the department, upon request.

Intent

Emergencies can happen any time. They may range from a pandemic, severe weather, fire, flooding, power outages, and gas leaks to lost children and threatening individuals. Children's records that are kept current help ensure that essential information on each child is documented and readily available for the protection of the child and the center.

Emergency planning can reduce the impact of a disaster by assisting providers to effectively handle the situation in the first impact of the disaster, which can result in maintaining a calm and safe

environment for the children in care. Emergency drills are necessary to prepare children and providers to respond appropriately to numerous potential emergencies.

Clarification

An emergency preparedness and response plan must describe the practices and procedures the program will use to prepare for and respond to emergency or disaster situations. It must address all types of emergency situations, including weather events, utility shut-off or outage, or a security risk. Providers should be aware of the differences between each action plan and when to implement the appropriate actions. The plan must apply to all children in care and address specific accommodations for infants and toddlers and children with disabilities and chronic medical conditions. Emergency plans are most effective if they are developed to meet the individual needs of a child care program and reviewed often enough to remain current. OLA created an *Emergency Preparedness and Response Plan template (https://dss.sd.gov/formsandpubs/docs/CCS/OLA-113.pdf)* to serve as a foundation to this process. Providers can choose to create their own emergency plan or use the template to assist in that process.

The first step in emergency planning is to develop an understanding of all the different types of hazards or emergencies associated with your area of the state and any vulnerability your program might have as a result of these hazards. For example,

- What potential disasters are identified in your region? (Flooding, tornadoes, etc.)
- What are potential risks due to the location of your program? (Blizzards, power outages, etc.)
- Are there any specific risks related to the location of your program?

You can develop awareness of different hazards through your local county emergency managers if necessary.

Evacuation plans address situations like a fire or gas leak in the building where people leave and move to a nearby, predetermined location. Sheltering in place is carried out during severe weather and other environmental hazards/threats with the goal of keeping people safe while remaining indoors. Lock-down procedures are used when there is a perceived threat/danger inside or outside of the building. The plan should also include a written relocation plan known to all providers.

According to the American Academy of Pediatrics, a thorough and safe evacuation plan includes a designated location that allows the children to get at least 50 feet away from the building, does not require the children or caregivers to cross the street, and provides shelter if the children cannot return to the building. Following an emergency situation, e.g., power outage, the provider should consult with their licensing specialist to determine if they can safely continue to provide care.

Routine practice of emergency drills fosters a calm, competent response to an emergency when it occurs. Conducting each type of drill (evacuation/relocation, shelter in place, and lock-down) a minimum of two times each calendar year ensures providers become and remain familiar with their roles. Inclement weather is a fact of life in South Dakota, so it is important to prepare for having to evacuate children during times of below zero temperatures, in snowstorms, in rainy weather, etc. The program should be able to evacuate all children to a safe location outside of the facility within two minutes of an emergency alarm. Documentation ensures that each type of drill has been carried out in a timely manner.

Things for child care programs to consider include:

- Have the fire evacuation procedure reviewed and approved by a fire official to ensure the evacuation routes and meeting location are ideal for children's safety.
- Designate a place to keep your plan so that it is available for quick access.
- Consult with local law enforcement officials on lock-down procedures.
- Practice drills at varying times to include various children and providers engaged in different activities so that everyone is familiar with procedures.
- Designate leadership roles for staff such as overseeing the response, first aid, communications, transportation, reunification, supplies, etc.
- Practice emergency drills using the same alarm that would be used during an actual emergency to ensure children are familiar with the sound and know how to respond.
- Keep hallways and rooms used for sheltering in place free of clutter. When possible, these areas should also be free from windows.
- Ensure exits remain unobstructed. Check for objects that may fall or block exits which could prevent safe evacuation.
- Use a crib designed to be used as an evacuation crib, a stroller with multiple seats, or a wagon for infants if rolling is possible on the evacuation route(s) and fit through designated fire exits.
- Keep an easy-to-carry emergency preparedness kit in a central location or in each classroom for provider's use during emergency situations and drills. Emergency kits should contain classroom rosters, first aid kits, and children's emergency contact information. Do not rely entirely on electronic records as computers may not be operational in an emergency.
- Store an empty medication "go pack" next to the medicine cabinet or refrigerator for easy access. This pack can be used to take medications, medication authorization forms, etc.
- Other potential items to include in the kit are drinking water, snacks, diapering supplies, books and/or activities for children's use at an evacuation site, etc.

While all providers must complete pre-service training within 90 days of employment that includes emergency planning, emergencies can happen at any time. New providers should be familiar with the plan as soon as they begin work at the program.

Liability insurance is valuable because, in the event of an injury or property damage, it can assist in covering costs incurred by the program, providers, and children in care. It can provide protection, economic security, and peace of mind.

Indicators

☑ Review the emergency planning and response plan to ensure that it addresses all types of emergencies and accommodation of infants and toddlers and children with disabilities or medical conditions as applicable.

☑ Review documentation of evacuation, shelter-in-place, and lock-down drills to confirm that they were held a minimum of twice each calendar year for each procedure.

☑ Discuss how newly hired providers are made familiar with the emergency plan.

☑ Ask to see a copy of the current liability insurance plan.

Resources and Forms

Department of Social Services – Emergency Preparedness and Response template and Drill Log: https://dss.sd.gov/childcare/blockgrant.aspx.

The South Dakota Department of Health provides links to state, government, professional organization, and volunteer resources available in the event of an emergency. Public Health Preparedness and Response | South Dakota Department of Health (sd.gov)

CFOC 4th ed. 9.2.4 Emergency/Security Policies and Plans addresses disaster planning, training, and communication for different types of emergencies at https://nrckids.org/CFOC/Database/9.2.4.3. It also provides a very inclusive list of items for first aid and emergency preparation kits at https://nrckids.org/CFOC/Database/5.6.0.1.

The Office of Head Start provides procedures for program staff to prepare and communicate information relating to Stay Safe (lockdown) drills.

South Dakota County and Tribal Emergency Managers contact information is at https://www.sd.gov/dps?id=cs_kb_article_view&sysparm_article=KB0043342&sys_kb_id=545a57d697462290447ef64ef053afdd&spa=1.

Caring for Our Children Basics (CFOCB) outlines a set of voluntary, foundational health and safety standards for early care and education programs. https://childcareta.acf.hhs.gov/cfoc

South Dakota ECE Shared Resources - https://sdece.org/resources/.

Handling, storage, and disposal of hazardous materials

ARSD 67:42:17:44

A. All toxic or hazardous substances must be:

1. Inaccessible to children;
2. Used according to manufacturer's instructions;
3. Stored in the original or other labeled container; and
4. Disposed of according to manufacturer recommendations.

Intent

There are over two million human poison exposures reported to poison centers every year. Children under six years of age account for over half of those potential poisonings. The substances most involved in poison exposures of children are cosmetics, personal care products, and cleaning substances. Hazardous substances must be in labeled containers to alert providers to their toxicity and provide instructions for proper use, information on accidental exposure, and how to inform the poison control center in the event of exposure. Proper and safe disposal further protects providers and children from accidental exposure.

Clarification

Toxic substances can be cleaning products, household chemicals, air fresheners, pesticides, medications, health and beauty aids, smoking products, and art materials. Programs should look for nontoxic products instead of those with the Environmental Protection Agency (EPA) label of caution, warning, or danger.

Plants are among the most common household substances that children ingest. Poisonous plants often have sharp thorns, berries, or prickly leaves and may cause reactions from skin irritation to life-threatening conditions.

Corrosive agents, bleaches, insecticides, detergents, polishes, products under pressure in aerosol cans, and any substance that may be toxic if ingested, inhaled, or handled should be kept in a locked cabinet or in an area that is clearly inaccessible to children. Providers' purses and diaper bags should be kept out of reach of children as well as classroom supplies that could be toxic.

Toxic substances, when ingested, inhaled, or in contact with skin, may react immediately or slowly, with serious symptoms occurring much later. It is important for the provider to call the poison center after the exposure and not "wait and see."

Indicators

- ☑ Observe the storage of hazardous items and supplies throughout the program and outdoors. Check product labels to ensure all items that are labeled "Keep Out of Reach of Children" are inaccessible.
- ☑ Confirm that toxic items are stored in a labeled container.
- ☑ Discuss the disposal of hazardous items.

Resources and Forms

Poison Control Center number: 1-800-222-1222.

Hazardous Materials Information for Child Care Providers | Child Care Technical Assistance Network (hhs.gov) provides multiple links to information on program standards, cleaning procedures, and pest management.

The EPA provides links to child care provider training and webinars, checklists, and tools on environmental safety at Healthy Child Care | U.S. EPA.

See CFOC 4th ed. Standard 5.2.9.1 Use and Storage of Toxic Substances, p. 243, for types of toxic substances, and Standard 5.2.9.3 Informing Staff Regarding Presence of Toxic Substances, p. 244 at CFOC4 pdf- FINAL.pdf (nrckids.org).

Caring for Our Children Basics (CFOCB) outlines a set of voluntary, foundational health and safety standards for early care and education programs. https://childcareta.acf.hhs.gov/cfoc

ARSD 67:42:17:44

B. Bio-contaminants must be handled and disposed of properly.

1. Soiled diapers must be changed promptly, in a designated area, on a non-porous surface.
2. The diaper changing area must be clean and disinfected with a sanitizing solution approved by the department.
3. Soiled diapers must be kept in a leakproof, nonabsorbent container that is covered with a tight-fitting lid.

Intent

Touching a contaminated object or surface may spread illnesses. Many types of infectious germs may be contained in human waste (urine, feces) and body fluids (saliva, nasal discharge, tissue and injury discharges, eye discharges, blood, and vomit). Because many infected people carry infectious diseases without having symptoms, and many are contagious before they experience a symptom, providers need to protect themselves and the children they serve by adhering to standard precautions.

Following recommended diaper changing procedures and disinfecting the diaper changing area is essential for preventing the spread of disease. There are many diarrhea-causing illnesses that can quickly turn into an outbreak without proper sanitation and handwashing.

Clarification

Standard precautions should be taken when contact with blood or other bodily fluids may occur. Precautions include use of protective gloves, handwashing, disposal of waste, and disinfecting surfaces.

The diaper changing area must be cleaned and disinfected after each use. Washing surfaces with a precise solution of bleach and water is an effective and economical method of sanitizing surfaces in child care. There are many products that claim to sanitize and disinfect diaper changing or food preparation surfaces, but none have been found to be as effective as bleach water in killing the germs associated with a diaper changing area.

An approved disinfecting solution is one ounce of household bleach to one quart of water or one-quarter cup of bleach diluted in one gallon of water. This solution should be mixed daily to maintain full strength. Disposable towels or tissues should be used, and mops should be rinsed in the disinfectant solution. Steam mops are acceptable for use to sanitize smooth surface floors.

Before using any disinfectant other than bleach, you must contact your licensing specialist for approval to use the product.

Indicators

- ☑ Discuss with the director and providers the proper handling and disposal of infectious materials.
- ☑ If possible, observe diaper changing, handwashing, and disinfecting. If not observed, discuss the procedures with providers and verify access to and safe storage of the disinfectant solution.
- ☑ Verify that the program is using a bleach solution to disinfect the diaper changing area or has approval to use another disinfectant.
- ☑ Verify the program has a leakproof, nonabsorbent container that is covered with a tight-fitting lid for proper disposal of diapers.
- ☑ Review program policies if available.

Resources and Forms

See CFOC 4th ed. Standard 3.2.3.4 Prevention of Exposure to Blood and Body Fluids, pgs. 123–124, for more information on Standard Precautions and Standard 5.2.7.6, p. 241 about disposal of toxic waste at CFOC4 pdf- FINAL.pdf (nrckids.org).

The California Child Care Health Program describes standard and universal precautions in the child care setting at standardprecen020305_adr.indd (ucsf.edu).

The CDC provides a one-page poster on diaper changing steps that can be posted in diaper changing areas. Safe and Healthy Diaper Changing Steps In Childcare Settings (cdc.gov).

See CFOC 4th ed. Standard 3.2.1.4 Diaper Changing Procedure, pgs. 113–115, for a detailed list of the eight steps to changing diapers and rationale for the steps at CFOC4 pdf- FINAL.pdf (nrckids.org).

See CFOC 4th ed. Standard 5.2.7.4 Containment of Soiled Diapers, p. 240, and Standard 5.2.7.5 Labeling, Cleaning, and Disposal of Waste and Diaper Containers, p. 241, for more information at CFOC4 pdf- FINAL.pdf (nrckids.org).

Caring for Our Children Basics (CFOCB) outlines a set of voluntary, foundational health and safety standards for early care and education programs. https://childcareta.acf.hhs.gov/cfoc

Transportation

ARSD 67:42:17:45

A. The following requirements apply to the transportation of a child:

1. A parent or guardian shall provide written permission for the transportation of their child;
2. The vehicle may not carry more people than its passenger capacity as stated on the label affixed to the vehicle under 49 C.F.R. Parts 567 and 568, in effect on March 9, 2022;
3. The required staff-child ratio must be maintained when children are being transported;
4. The driver must be at least eighteen years of age and have a driver's license to operate the vehicle being driven;
5. When a child is being transported in a vehicle other than a bus, the child must be restrained in a car seat, booster seat, or seat belt appropriate for the child's weight and age; and
6. Proof of liability insurance must be provided to the department, upon request, for any vehicle used for transporting children.

Intent

The purpose of this section is to ensure the safety of passengers during transportation. The use of restraint devices, if used properly, reduces the likelihood of any passenger suffering serious injury or death if the vehicle is involved in an accident. Obtaining written permission helps to ensure parental awareness of the program's activities and to ensure parents have given permission and clear instructions before transportation is provided. They will likely want to know what vehicles will be used, who will be transporting children, and for what purpose, e.g., field trips, to and from school, medical emergencies. Meeting staff-child ratios ensures that adequate providers are available to supervise and to protect children during transportation, particularly in case of an emergency.

Transporting children is a significant responsibility, and drivers must be responsible and have the maturity to supervise children while driving and be able to respond appropriately to emergency situations. Drivers also must be licensed for the type of vehicle they may be asked to drive.

Clarification

Providers should obtain written permission from parents to transport children or utilize community transportation and school buses. Permission may be included on the child information form or accepted by email or text if it contains the necessary information, and a copy is kept on file at the program. The provider may determine if they wish to obtain one-time permission or permission for specific purposes such as each field trip. Communication with parents regarding transportation occurrences outside of routine school pick-up and drop-off (e.g., field trips) should be maintained. A sample child information form that includes transportation permission is provided on the DSS website - https://dss.sd.gov/formsandpubs/docs/CCS/OLA-102_APPLICATION_FOR_ADMISSION_TO_CHILD_CARE.pdf.

Many insurance companies may require that a driver be 21 years of age, so check your coverage. Requirements regarding age, license, and documentation of vehicle insurance must be met by all drivers including a parent or other volunteer. Any providers or parent volunteers who transport children who are not their own must meet the provider requirements, including a cleared background screening, orientation training, and current pediatric CPR certification.

Providers who transport children should have clear instructions on handling emergency breakdowns and accidents, including vehicle evacuation procedures and contacting emergency help and parents.

Programs choosing to provide transportation must adhere to state safety restraint (seat belts and car seats) laws outlined in SDCL 32-37-1, 32-37-1.1, and 32-37-1-1.2 at https://sdlegislature.gov/Statutes/Codified_Laws/2055337. These laws require:

- A child under five years of age is to be properly secured in a child passenger restraint system according to its manufacturer's instructions.
- Seat belts can be used for children five years of age or older, if the child is at least 40 pounds in weight. A five-year-old child who weighs under 40 pounds would be required to be secured in a child passenger restraint system.
- Passengers who are at least five and under 18 years of age shall wear a properly adjusted and fastened safety seat belt system.
- Any driver who is at least 14 years of age and under 18 years of age shall wear a properly adjusted and fastened safety seat belt system.

No more than one person is intended to be secured in each seat belt. School buses that do not have seat belts are not required to provide child restraint systems.

If the program provides child safety seats, the seats should be replaced if they have been recalled, are past the manufacturer's 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 these car safety seats after a crash.

Indicators

☑ Review children's records including permission forms. Programs should periodically check permission forms to ensure that they have permission for each transported child and that permission forms are up to date.

- ☑ Check documentation of the vehicle manufacturer's rated seating capacity for each vehicle used to transport children. If possible, observe children in vehicles to check for compliance, or count the number of installed seat belts to determine the number of persons who can occupy the vehicle used for transportation.
- ☑ Observe staffing ratios on vehicles during transportation, if possible. If transportation is not observed, documentation of a transportation log and staffing levels can be requested.
- ☑ Review copies of the appropriate type of driver's licenses for anyone who may transport children.
- ☑ When possible, observe children on vehicles to verify that all children are properly secured in a child safety seat and/or a seat belt in accordance with state law, installed and used properly, and in good condition. If transportation is not observed, check the vehicle and child safety seats and/or seat belts to ensure seat belts and car seats are installed, in working order, and in good condition.
- ☑ View documentation of current vehicle coverage outlined in Certificate of Liability.

Resources and Forms

See CFOC 4th ed. Standard 9.2.5.1 Transportation Policy for Centers and Large Family Homes, p. 402 for more information on transportation policies. CFOC4 pdf- FINAL.pdf (nrckids.org).

To better understand which safety restraint is appropriate, how to install a car or booster seat, and where to get a car seat safety check, call 1-866-SEAT-CHECK or go to the U.S. Department of Transportation's webpage at seatcheck.org.

Caring for Our Children Basics (CFOCB) outlines a set of voluntary, foundational health and safety standards for early care and education programs. https://childcareta.acf.hhs.gov/cfoc

Pediatric first aid and cardiopulmonary resuscitation

ARSD 67:42:17:46

A. A provider shall complete pediatric first aid training every five years and maintain documentation of the training. A provider must be certified in pediatric cardiopulmonary resuscitation. The certification must include a hands-on skills test.

B. A provider shall work under supervision until the provider has completed the training required by this section. The supervisor shall have completed their pediatric first aid training and be certified in pediatric cardiopulmonary resuscitation.

Intent

Knowledge of pediatric first aid, including pediatric CPR, which addresses management of a blocked airway and rescue breathing, and the confidence to use these skills, are critically important to the outcome of an emergency situation. For emergency situations that require attention from a health professional, first aid procedures can be used to control the situation until a health professional can provide medical care. Response to a blocked airway (choking) is a life-threatening emergency that cannot wait for emergency medical personnel to arrive on the scene. Pediatric CPR and first aid training is designed to concentrate on medical emergencies that affect children in a unique way. In the minutes immediately following an emergency, how quickly a child is treated can significantly impact their future health.

Clarification

Pediatric CPR must include hands-on skill testing to ensure the technique can be performed in an emergency. An online study that includes an in-person demonstration and skills test is acceptable.

Since medical emergencies can occur during transportation activities, training is also required for drivers unless other providers are in the vehicle.

Documentation of training should include the participant's name, date of the training, title of the training, the trainer or training organization's name, the expiration or renewal date of the training as determined by the organization providing the training, and the number of training hours.

In general, first aid training must be taken every five years to align with the federal orientation training and progressive training requirements. Each provider must maintain a valid certification in pediatric CPR as demonstrated by the expiration or renewal date on the card.

Indicators

☑ Review original copies of first aid and CPR documentation, ensuring that the training is designated as "pediatric." Documentation may include a certificate, a written statement from the instructor, or a class roster that includes the items listed above. Check the expiration or renewal date to ensure the training has not expired.

Resources and Forms

To check on available first aid and CPR training, contact your local Early Childhood Enrichment Program at https://dss.sd.gov/childcare/educationalopportunities/default.aspx.

See CFOC 4th ed. Standard 1.4.3 First Aid and CPR Training, pgs. 26–28, for more information including topics that should be covered in first aid training at CFOC4 pdf-FINAL.pdf (nrckids.org).

A first aid and emergency supply list is provided by CFOC, 4th ed. at AppendixNN.pdf (nrckids.org).

Reporting of child abuse and neglect

ARSD 67:42:17:47

A. A child care provider shall immediately report any suspected abuse or neglect of a child to Child Protective Services, law enforcement, or the State's Attorney's office and cooperate fully in the investigation of any incident.

Intent

Education on child abuse and neglect and the requirements for reporting can increase the number of appropriate referrals to Child Protection Services, which help protect children who may have been neglected or abused.

Having written procedures and ensuring employee awareness of child abuse reporting requirements is essential to the prevention of child abuse and helps to ensure proper employee response if they suspect child abuse has occurred.

Clarification

Child abuse includes physical, sexual, psychological, and emotional abuse. Other components of abuse include shaken baby syndrome/acute head trauma and repeated exposure to violence, including domestic violence. Neglect occurs when an adult does not meet the child's basic needs and includes physical, medical, educational, and emotional neglect.

SDCL 26-8A-3 states that providers in licensed programs who have reasonable cause to *suspect* that any child under the age of 18 years has been abused or neglected, as defined by SDCL 26-8A-2, are considered mandatory reporters of child abuse and neglect and are to report that information to one of these three entities:

- The Department of Social Services (DSS) abuse reporting hotline at 1-877-244-0864 from 8 am to 5 pm Monday through Friday;
- The State's Attorney office; or

- A local law enforcement office.

There is also a National Child Abuse Hotline at 1-800-4ACHILD.

Failure to report child abuse and neglect is a misdemeanor and is both a violation of child care rules and state law. There is a penalty of one year in jail and/or a $2,000 fine for any mandatory reporter who does not report suspicions of abuse.

If you are unsure as to whether an incident would be considered child abuse or neglect or where it might have occurred, it is better to err on the side of protecting the child and report it. It can then be determined if the situation meets the definition. Reports do not always mean a child is removed from the family. There are many services that Child Protection has available to families going through a rough time that can help a parent and protect children.

Every child care provider is still liable for reporting suspected abuse or neglect even when their program director does not agree or says that someone else will report it. Providers who report in good faith may do so confidentially and are protected by law.

Indicators

☑ Discuss mandatory reporting laws with providers to confirm their understanding of all providers' responsibilities.

☑ Review personnel files to verify that all providers have signed the statement acknowledging their reporting responsibility.

Resources and Forms

Acknowledgement of Responsibility to Report Suspected Child Abuse and Neglect includes signs and symptoms of abuse and neglect, a reporting policy, and an acknowledgement statement for staff to sign and is available on the DSS website at https://dss.sd.gov/formsandpubs/.

CFOC 4th ed. provides a fact sheet from the Child Welfare Information Gateway at Appendix M, pgs. 494–499, that provides signs and symptoms and how child care programs can help prevent abuse and neglect at CFOC4 pdf- FINAL.pdf (nrckids.org).

The website for South Dakota's Center for the Prevention of Child Maltreatment includes the do's and don'ts when a child discloses abuse at Reporting Child Abuse – Center for the Prevention of Childhood Maltreatment (sdcpcm.com).

Guidelines for Child Care Providers on How to Report Suspected Abuse or Neglect – eXtension Alliance for Better Child Care includes questions you may be asked when reporting abuse or neglect.

Caring for Our Children Basics (CFOCB) outlines a set of voluntary, foundational health and safety standards for early care and education programs. https://childcareta.acf.hhs.gov/cfoc

Night-time care

ARSD 67:42:17:48

A. If care is provided between 7:00 p.m. and 6:00 a.m., the following requirements apply:

1. Center providers on duty must be awake and alert to the needs of children.
2. Providers shall provide a cot or bed for each child in overnight care.

Intent

To ensure that the needs of children in night-time care are met.

Clarification

In addition to the above standards, a program providing night-time care must adhere to the same regulations as a program providing day-time care including staff-child ratios.

When the same premises are used for the provision of day and night care, the number of children during overlapping shift periods may not exceed the maximum licensed capacity of the program.

Indicators

- ☑ Ask where providers are located at night to ensure that they are alert to the needs of children.
- ☑ Observe the cots or beds that are used for night-time care.
- ☑ Review attendance records to verify that the maximum capacity is not exceeded during overlapping shifts.

Resources and Forms

See CFOC 4th ed. Standard 9.2.3.13 Plans for Evening and Nighttime Child Care, p. 390, regarding safety precautions to allow for timely evacuation in case of emergency at CFOC4pdf- FINAL.pdf (nrckids.org).

Parental access

ARSD 67:42:17:49

A. A parent must be allowed to observe their child or children at any time.

B. A parent must be notified by the provider immediately regarding any serious injuries received while the child is under care of the provider.

C. A parent must be notified by the provider within twenty-four hours of any changes in circumstances. For purposes of this section, the term, changes in circumstances, means a change in the provider's license, the suspension or revocation of the provider's license, a change in the program location, closure of the program, and a change in ownership of the program.

D. If a court order restricts a parent from having contact with a child, and if the provider has been given a copy of the court order, the provider shall deny access to the parent.

Intent

Parents should be encouraged to observe and participate in the care of their children. Allowing parents unrestricted access to their children and areas of the premises used by children is essential for parents' ability to monitor the care their child is receiving. It also is a tool in preventing the abuse and neglect of children in care. When access is restricted, areas observable by the parents may not reflect the care the children receive in the rest of the program. However, obeying court orders that restrict parental access serves to protect a child.

Parental notification of their child's serious injury allows parents to respond immediately in obtaining medical or dental attention and possibly treatment. Notification of changes in circumstances is necessary for parents to make alternative arrangements if needed.

Positive relationships between providers and families allow for open communication should challenges arise and could help reduce the number of complaints.

Clarification

While parents must be permitted to enter child care areas, the program may have a policy requiring authorized individuals and parents to check in with a provider before entering the children's areas to ensure safety of the children in the program. There may also be circumstances when full access can jeopardize safety, e.g., during a pandemic, and be limited. Any policies should be communicated to parents and the reasons explained.

If a provider chooses to keep the building locked for security reasons, parents must have the information necessary to enter the building.

Completion of a Serious Injury Report provides documentation that a parent was notified immediately in the event of a serious injury such as a broken bone, deep cut, or bump on the head.

Injury report forms can be periodically reviewed by providers to identify patterns of children's injuries that may be preventable or could indicate possible abuse or neglect. They also provide a record that can be shared with parents or address liability.

While parents must be notified immediately of any serious injuries that may require medical or dental attention, parents should be notified of less serious injuries when they pick up their child from the program. Less serious injuries include minor cuts, scratches, and bites from other children requiring first aid treatment by providers.

Parental notice of changes in program circumstances can be verbal if documented, but a written or posted notice is preferable and should include enough information to address most parental concerns. While parents must be notified within 24 hours of any changes that may impact the program operation, advance notification to parents of known changes is always preferable as it may affect their options and choices. Communication with parents that may impact care of their children such as a closure, change of ownership, revocation, suspension, etc., should be reported to parents within 24 hours of notification of the department. Other changes in circumstances may include a new director or provider, their child's exposure to a reportable disease, or a revised program policy.

If there is a court order restricting a parent's or other person's access to their child, the provider should request and maintain a copy of the order and notify other providers with a need to know. A program should always follow the parent's instructions regarding access to their child by persons other than a parent and be aware of who has permission to pick up the child. A director may also want to consider what legal information they would need regarding custody agreements. It is best to have open communication with both parents to understand the situation.

Indicators

- ☑ Ask about the program's policy on parental access during the program's operational hours.
- ☑ Observe parents' access to the premises, if possible.
- ☑ Review any documentation, when available, such as relevant program policies and procedures on parental access or serious injury reporting.
- ☑ Review dated copies of parent notification of any changes in circumstances.
- ☑ Review individual program policy information if available.

Resources and Forms

CFOC 4th ed. Standard 9.4.1.11 Review and Accessibility of Injury and Illness Reports, p. 414, addresses the use of injury logs to identify possible injury prevention actions at CFOC4 pdf- FINAL.pdf (nrckids.org).

Information about family engagement and the importance of parental involvement can be found at https://www.naeyc.org/resources/topics/family-engagement.

South Dakota ECE Shared Resources - https://sdece.org/resources/.

Children's records

ARSD 67:42:17:42

A. A provider shall maintain a record for each child that includes:

1. The child's name and date of birth;
2. The parent or guardian's name and telephone number;
3. An emergency contact name and telephone number;
4. Parental permission for emergency medical treatment;
5. The names of individuals authorized to pick up child;
6. Health information, including any allergies or special needs;
7. A current immunization record, or for a school-age program, the name of the child's school;
8. Parental permission for medication;
9. The child's attendance records;
10. The date of the child's enrollment; and
11. The date on which the child's enrollment ends.

B. The provider shall annually review and update each record required under this section, and make the child's record available to the department, upon request.

Intent

Children's records that are kept current help ensure that essential information on each child is documented and readily available for the protection of the child and the center.

Clarification

A record must be kept on each child enrolled in the program and made available to the department upon request. To help ensure that the center has up-to-date information in children's records, parents should be asked to notify providers of any changes when they occur, and the record should be reviewed and updated at least annually. You may want to establish a routine for periodically reviewing and updating all children's record information (e.g., at the beginning of each school year, at

the start of the new calendar year). It is advisable to keep these records for six months after the child is no longer enrolled. For providers serving families receiving Child Care Assistance, the attendance records need to be retained for four years.

If a family struggles to identify an emergency contact, explain that it could be a family member out of state who knows the child's health history or a friend, neighbor, or a co-worker who could help contact the family. You can also clarify that the emergency contact person is not authorized to make medical decisions but just to help reach the parents. It should be noted in writing if the parent chooses not to designate anyone.

It is important to know who is authorized to pick up a child, especially if custody is an issue. Pick-up times can be busy for providers, so having clear policies on the safe release of children is critical, especially for substitute providers who may not know the parents. If a parent calls, texts, or emails about someone picking up their child that's not listed on the child's records, it needs to be documented for the provider's protection.

Child care programs must maintain health information for each enrolled child, including any allergies or special needs, to ensure providers are able to appropriately observe and respond to children's physical and medical needs. A current immunization record must be on file for each child attending the program. For programs licensed as school-age programs, the name of the child's school may be documented in lieu of obtaining the child's immunization record. For additional information regarding medication permission and administration, refer to Chapter VIII (67:42:17:25) on Medication Administration.

Attendance records are important for accounting for children in an evacuation or at the end of the day, planning for meals and snacks, and complying with staff-child ratios. Attendance records can be kept for all enrolled children or by classroom rather than for each child.

All children's records are to be located at the facility site where the child is in care so that providers have ready access to them and DSS can review for compliance.

Indicators

☑ Review 25% of children's records or a minimum of 20 records, whichever is greater, to ensure that they contain all required information. Look for evidence of records being updated. Additional records should be reviewed if concerns exist.

Resources and Forms

Child Information, a sample form to be used upon a child's admission to child care and updated regularly, and an Attendance Record are available on the DSS website at https://dss.sd.gov/formsandpubs/.