Introduction to Child Care Licensing
Every day, thousands of Utah children are being cared for outside of their own homes. Child Care Licensing serves Utah's communities by ensuring that child care facilities meet standards that keep children healthy and safe while in out-of-home care.

Child Care Licensing (CCL) is a program within the Bureau of Licensing and Certification under the authority of the Utah Department of Health and Human Services. The purpose of the program is to ensure a healthy and safe environment for the children in child care settings through regulation of both residential and center child care facilities.

CCL staff are accountable to:
- Monitor child care facilities for compliance with federal and state laws and regulations.
- Offer technical assistance and training to child care providers.
- Ensure that all individuals involved with child care pass background checks.
- Investigate complaints that allege rule violations and unlicensed care.
- Inform parents and the public about child care in Utah. Each child care provider’s public licensing record is available on the Child Care Licensing website at: childcarelicensing.utah.gov.

Child Care Licensing Vision
Access to safe, healthy child care for Utah families.

Child Care Licensing Mission
To support working parents by protecting the health and safety of children in child care programs we oversee. This is accomplished by:
- Establishing and assessing health and safety standards.
- Training and supporting providers in meeting the established standards.
- Providing the public with accurate information about these child care programs.

Code of Ethics
CCL has adopted the Code of Ethics published by the National Association for Regulatory Administration (NARA). The Code requires CCL employees to use their authority with integrity, thus prohibiting certain actions.
CCL employees will not:
- Use their positions for personal gain from those they regulate.
- Apply regulations inconsistently because of favoritism, nepotism, or personal bias.
- Regulate someone with whom they have or have recently had a significant financial or personal relationship.
- Exceed the authority delegated to them by laws and regulations.
• Accept services, favors or gifts, including food, treats, gift certificates, or handmade gifts from those they regulate.
• Depart from established CCL procedures therefore ensuring fair and objective enforcement.

NARA Code of Ethics

Child Care Licensing Rules
Utah wants the best for its children and therefore laws are enacted to promote the healthy growth, development, and protection of children. The Utah Child Care Licensing Act authorizes the Utah Department of Health and Human Services to establish rules regarding child care that implement state law. The Department of Health and Human Services's Child Care Licensing program is delegated with the authority to interpret and enforce these rules that have the same effect as law. It is the child care provider’s responsibility to understand and follow licensing rules in order to keep children safe and healthy.

Licensing rules focus on the foundational standards necessary to keep children safe and healthy while in care. The rules are based on current research and guidance from recognized experts in the field. A primary source of information is the publication Caring for Our Children: National Health and Safety Performance Standards; Guidelines for Early Care and Education Programs, 4th Edition (CFOC). It is published by the American Academy of Pediatrics, the American Public Health Association, and the National Resource Center for Health and Safety in Child Care and Early Education.

Licensing rules also reflect recommendations from the Consumer Product Safety Commission (CPSC) and ASTM International (ASTM). CPSC is a U.S. government agency responsible for ensuring the safety of consumer products including toys, cribs, and household chemicals. ASTM is a recognized leader in researching and setting standards that improve product quality and safety.

Licensors
To make sure inspections are conducted equitably, effectively, efficiently, and in accordance with local and federal requirements, our licensors go through extensive training. First, we hire individuals with experience in child care and with degrees in child development or other related fields. Second, new licensors go through at least 480 hours of targeted training before they conduct inspections on their own. Training includes, but is not limited to:
- Prevention of sudden infant death syndrome and use of safe sleeping practices
- Administration of medication
- Prevention and response to emergencies due to food and allergic reactions
- Building and physical premises safety, including identification of and protection from hazards, bodies of water, and vehicular traffic
- Prevention of shaken baby syndrome, abusive head trauma, and child maltreatment
- Emergency preparedness and response planning for emergencies resulting from a natural disaster, or a man-caused event (such as violence at a child care facility)
- Handling and storage of hazardous materials and the appropriate disposal of biocontaminants
- Appropriate precautions in transporting children
- Pediatric first aid and cardiopulmonary resuscitation
- Recognition and reporting of child abuse and neglect
- Caseload management
- Handling difficult conversations and effective communication
- Child Development
- Time management
- Cultural and linguistic diversity awareness
- Equity
- Teamwork, professionalism, and work ethics

Third, Child Care Licensing staff receive at least 50 hours of ongoing annual training. This training includes all previously stated topics in addition to our program specific and HR related topics.

Licensors are organized in specialized teams and according to provider setting: Homes, Centers, and License Exempt. Their caseloads vary depending on their individual teams and other assignments.

The licensor's average caseload is: Homes licensor 1/120, Centers licensor 1/90, and License Exempt licensor 1/140.

Some of our licensors are also trained and assigned to conduct complaint investigations.

**Inspection Process**

CCL ensures compliance to licensing rules through ongoing inspections of child care facilities, thus preventing the continued operation of substandard child care programs. Inspections are conducted onsite, and on very rare occasions they are conducted remotely. To make sure inspections are conducted in a timely manner, licensors receive automated inspection required alerts. These and other required assignments are closely monitored by their supervisor.

During inspections, a licensor will:
- Inspect all rooms, indoor and outdoor areas (including sheds, garages, storage areas, campers, etc.), playground equipment, and items that are accessible to children in care.
- Check that there are no children or illegal items in rooms and areas that are inaccessible to children. A locked room will not need to be opened if there is a way for the licensor to view the entire room without unlocking it.

Please refer to “Section 2 - Definitions” to better understand the definition of “inaccessible”.

To verify compliance with the rules and depending on the inspection type, a licensor may:
- Ask for a government issued photo ID to confirm all covered individuals have passed a CCL background check.
- Open and observe the contents of any container, drawer, cupboard, room, or area, etc. that is accessible to children.
- Ask clarifying questions.
• Review records – the facility's general paperwork, each covered individual's records, and the records kept for each child in care. A list of required records is found in the Appendix of this manual.
• Observe a diaper change if there are diapered children in care at the time of the inspection.
• Inspect each vehicle used to transport the children.
• Take pictures of items in order to better explain a situation to their manager and/or to be used as documentation of a rule violation.
• Interview staff, children, and/or parents of enrolled children.
• Ask for written statements.
• Record audio statements.
• Bring additional CCL staff to help with the inspection, depending on the size of the facility or as instructed by their supervisor.

The licensors use standardized checklists to ensure consistency for each inspection. These checklists are published on the CCL website under “Forms and Documents”. Once inspections receive managerial approval, checklists used during those inspections are posted on our website to show all items observed during the inspection. Normally, licensors have two business days to complete their report after the inspection is complete, then managers have two more business days to review and approve. These inspection checklists are part of the full monitoring and inspection report found at Child Care Facility Record. We display three years of each provider’s compliance history on our website.

If there are any inaccuracies on any of our reports or inspection results, providers have the opportunity to contact us and request that correction. They can also use their 10-day right to appeal and submit a manager review request to facilitate any needed corrections.

If anyone is interested in a provider's compliance history and does not have access to the internet, they can contact any of our staff and get that information on the phone as a file review.

CCL conducts several types of inspections that are described below. However, every facility will normally have one annual announced and one annual unannounced inspection each year.

**Pre-License Inspection**
This inspection is conducted before a new child care license is issued. At the Pre-License Inspection, an applicant for a child care license must demonstrate that they are in compliance with all licensing rules. It is also at this time that a licensor will measure the facility's area with a laser distance measure to calculate square footage, and assess other requirements in determining the facility's capacity.

**Announced Inspection**
An Announced Inspection is conducted annually at each facility to ensure that all licensing rules are in compliance. This inspection is scheduled with the child care provider and usually takes place 30 to 90 days before the license expiration date. Depending on the size of the facility and the number of staff and enrolled children, the Announced Inspection takes approximately one to three hours to complete. The inspection process will proceed more quickly and smoothly if:
• The provider is not scheduled for other duties during the inspection, such as transporting children, preparing meals, etc.
• Keys to locked areas of the facility are readily available. Rooms and areas that are locked to make them inaccessible should not be unlocked until requested by the licensor.
• Providers tell the licensor when a child is ready to be diapered.
• Vehicles are available to be inspected some time during the inspection.
• Required paperwork is completed, organized, and available for review.

Unannounced Inspection
Each facility will receive an Unannounced Inspection annually. This inspection is not scheduled with the provider and takes place sometime during the licensing year. Its purpose is for CCL to ensure that a child care provider is in compliance with licensing rules at all times a child is in care, even when an inspection is unexpected. The Unannounced Inspection takes less time to conduct because paperwork is generally not assessed.

Follow-up Inspection
Licensors conduct a Follow-up Inspection to verify that any rule violations found in previous inspections are corrected, and to ensure that there are no new, serious violations. Follow-up Inspections are always unannounced.

Complaint Investigation
In addition to the previously mentioned regular inspections, complaints with allegations of rule violation are investigated by a complaint investigator. The type and scope of each investigation vary based on the information received in the complaint. Complaint Investigations can be announced or unannounced. Depending on the information received or witnessed, Complaint Follow-up Inspections may be conducted.

Monitoring Inspection
This inspection is unannounced and conducted to check for specific compliance issues in facilities that are operating under a conditional status. The frequency of these inspections depends on the conditions set by CCL when the facility's child care license was placed on a conditional status.

Focus Inspection
This type of inspection is conducted when there is a specific issue, unrelated to a complaint, that needs to be addressed outside of the regular Announced and Unannounced Inspections.

After Each Inspection
At the end of or after each inspection, the licensor will:
• Inform the provider of the results of the inspection.
• Explain any rule violations to the provider.
• Give the provider an opportunity to discuss each violation and provide feedback.
• Decide, with the provider, on a correction date for each violation. However, if any violation poses a serious risk to the children, a date of correction may not be negotiated, but will be set by the licensor.
• Ask the provider to sign the electronic checklist as acknowledgment that the inspection was conducted and concluded. The provider’s signature does not indicate their agreement with the results of the inspection.
• Email the checklist to the provider before leaving the facility.
• After management approval, send an Inspection Report to the provider explaining any rules found out of compliance, each rule violation’s level of risk or harm, CCL's corrective action, and a due date for each rule violation to be corrected.
• Conduct an unannounced Follow-up Inspection to verify that all rule violations have remained or been corrected, and that there are no new, serious violations.

The provider will have an opportunity to give feedback to CCL about each inspection. Additionally, providers have 10 working days to appeal any action taken by CCL. This includes appealing CCL's determination of a rule violation, a corrective action, and the assessment of a Civil Money Penalty. The appeal period begins on the date that the provider receives official notification of a CCL action, such as receiving the Inspection Report.

Child Care Provider Bill of Rights

Purpose and Use of the Interpretation Manual
This manual has been prepared for child care owners, providers, caregivers, parents, and licensing staff to ensure statewide consistency in the understanding and enforcement of CCL rules. It provides a general overview of licensing rules and gives additional information to broaden knowledge about the intent and meaning of specific rules.

The manual is divided by rule categories into 24 sections with each section containing four main types of information:
• Rule – The actual rule text is printed in a black bold font.
• Rationale / Explanation – This explains the reason for a specific rule or section of rules, it frequently describes best practice but not rule assessment.
• Compliance Guidelines – This provides guidance in achieving and maintaining compliance with a specific rule.
• Risk Level - This describes the level of risk or harm that occurred or is likely to occur due to a rule violation.
• Corrective Action for 1st Instance – This describes the first corrective action that CCL will take if the rule is violated. See “Section 5: Rule Violations & Penalties” for more information.

As our knowledge of what is best for children grows and as CCL engages in continuous improvement, this manual will be periodically updated. The manual is found on the CCL website at: childcarelicensing.utah.gov.
R430-50-1. Rule Interpretation Manual:
Legal Authority and Purpose

The authority to enforce licensing rules and the purpose of these rules is explained in this section.

(1) This rule is enacted and enforced in accordance with Title 26, Chapter 39, Utah Child Care Licensing Act.

(2) This rule establishes the foundational standards necessary to protect the health and safety of children in residential child care facilities and defines the general procedures and requirements to get and maintain a residential certificate to provide child care.

Rationale/Explanation
The Utah Department of Health has the legal responsibility to regulate child care providers as outlined in Utah Code, Title 26, Chapter 39, also known as the Utah Child Care Licensing Act.

Child Care Licensing (CCL) in the Department of Health is the program delegated with the authority to make and enforce rules to carry out the Child Care Licensing Act.

The purpose of the rules is to ensure the health and safety of children in child care facilities. The rules also explain how to obtain and keep a license to provide child care in Utah.
A new rule may be required due to new law, research, practice, or a request of committees, providers, staff, or community.

CCL drafts the rule and presents it to the committees and the Department for review and discussion.

If approved, the proposed rule will follow the legal process and then is posted for public comment.

The new rule is published with an effective date.

The Department's legal counsel and the Executive Director approve the rule to take effect.

Public comments are reviewed by the Department and the committees.

CCL informs providers, staff, and the community of the new rule effective date.

The rule takes effect and is posted on the CCL website.

CCL updates the Rule Interpretation Manual and offers training on the new rule.

- Occasionally, a proposed rule may not be approved, including when a concern can be addressed by an update to the Rule Interpretation Manual or the enforcement protocol.
- The Rule Interpretation Manual and updates are posted on the CCL website. The Manual is generally updated annually.
- CCL offers training on licensing rules on a regular basis.
This section provides definitions of words that are specific to Child Care Licensing (CCL) or are used multiple times in licensing rules.

(1) "Applicant" means a person or business who has applied for a new or a renewal of a residential certificate from Child Care Licensing.

(2) "Background Finding" means information in a background check that Child Care Licensing uses to determine if a covered individual is or is not eligible to be involved with child care.

Rationale/Explanation
Refer to “Section 8: Background Checks” for a complete description of the reasons why an individual will not pass a CCL background check. According to Utah statute 26-39-404, a licensee or an exempt provider may not permit a person who has been convicted, has pleaded no contest, or is currently subject to a plea in abeyance or diversion agreement for any felony or misdemeanor to provide child care, volunteer, reside, or serve in any ownership or administrative capacity in a child care facility or program.

(3) "Barrier" means an enclosing structure such as a fence, wall, bars, railing, or solid panel to prevent accidental or deliberate movement through or access to something.

(4) "Body Fluid" means blood, urine, feces, vomit, mucus, or saliva.

(5) "Business Days and Hours" means the days of the week and times the facility is open for business.

(6) "Caregiver" means a covered individual who protects the health and safety of children. A covered individual is a caregiver when they:
   (a) count in the caregiver-to-child ratio;
   (b) meet the physical or emotional needs of the children, including diapering, toileting, feeding, or protecting them from harm; or
   (c) supervise children.

(7) "Capacity" means the maximum number of children the provider is allowed to care for at any given time.

(8) "Caregiver-to-Child Ratio" means the number of caregivers responsible for a specific number of children.
(9) "CCL" means the Child Care Licensing program in the Department of Health that is delegated with the responsibility to enforce the Utah Child Care Licensing Act.

(10) "Child Care" means continuous care and supervision of five or more qualifying children that is:
   (a) in place of care ordinarily provided by a parent in the parent's home;
   (b) for less than 24 hours a day; and
   (c) for direct or indirect compensation.

**Rationale/Explanation**
Indirect compensation is a non cash payment of goods, time, or service that is given to the provider in exchange for providing child care.

(11) "Child Care Program" means a person or business that offers child care.

(12) "Choking Hazard" means an object or a removable part on an object with a diameter of less than 1-1/4 inches and a length of less than 2-1/4 inches that could be caught in a child's throat blocking their airway and making it difficult or impossible to breathe.

(13) "Conditional Status" means that the provider is at risk of losing their child care residential certificate because compliance with licensing rules has not been maintained.

(14) "Covered Individual" means any of the following individuals involved with a child care program:
   (a) an owner;
   (b) an employee;
   (c) a caregiver;
   (d) a volunteer, except a parent of a child enrolled in the child care program;
   (e) an individual age 12 years or older who resides in the facility; and
   (f) anyone who has unsupervised contact with a child in care.

(15) “Crib” means an infant's bed with sides to protect them from falling including a bassinet, porta-crib, or playpen.

(16) "Cushioning" means a shock-absorbing surface under and around play equipment that reduces the severity of injuries from falls.

(17) "Department" means the Utah Department of Health.

(18) "Designated Play Surface" means any accessible elevated surface for standing, walking, crawling, sitting or climbing; or an accessible flat surface at least two by two inches in size and having an angle less than 30 degrees from horizontal.
(19) "Eligible" means that were no findings in a covered individual's background check that could prohibit that covered individual from being involved with child care.

(20) "Emotional Abuse" means behavior that could harm a child's emotional development, such as threatening, intimidating, humiliating, demeaning, criticizing, rejecting, using profane language, or using inappropriate physical restraint.

(21) "Entrapment Hazard" means an opening greater than 3- 1/2 by 6-1/4 inches and less than nine inches in diameter where a child's body could fit through but the child's head could not fit through, potentially causing a child's entrapment and strangulation.

(22) "Facility" means a child care program or the premises approved by the department to be used for child care.

**Rationale/Explanation**
The “premises” means the provider’s building (or buildings) and grounds.

(23) "Group" means the children who are assigned to and supervised by one or more caregivers.

**Rationale/Explanation**
Children who are supervised by one or more caregivers in a defined outdoor area are also considered a “group.”

(24) "Group Size" means the number of children in a group.

(25) "Guest" means an individual who is not a covered individual and is at the child care facility for a short time with the provider's permission.

(26) "Health Care Provider" means a licensed health professional, such as a physician, dentist, nurse practitioner, or physician's assistant.

(27) "Homeless" means anyone who lacks a fixed, regular, and adequate nighttime residence.

(28) "Inaccessible" means out of reach of children by being:
   (a) locked, such as in a locked room, cupboard, or drawer;
   (b) secured with a child safety device, such as a child safety cupboard lock or doorknob device;
   (c) behind a properly secured child safety gate;
   (d) located in a cupboard or on a shelf that is at least 36 inches above the floor; or
   (e) if in a bathroom, at least 36 inches above any surface from where a child could stand or climb.

**Rationale/Explanation**
Providers must ensure that children are safe by making potential hazards inaccessible.

Approved locking equipment includes:
- Devices specifically manufactured as child safety products such as baby safety gates, child safety locks, and other child safety fastening devices. Child-resistant packaging (such as a medicine bottle safety cap) is not approved locking equipment.
- Locks that use a key or combination to unlock them.
- Locks that use a coin, allenwrench, or similar additional tool to unlock them except when used to lock firearms.
- Locks that do not use a key or combination, such as a deadbolt or hook-and-eye latch, when they are installed at least 60 inches high.
- Properly secured homemade or manufactured child safety gates that are at least 24 inches high from the floor to the top of the gate. The gap between the floor and the bottom of the gate cannot exceed 5 by 5 inches.
- Zip ties, except when used to lock firearms.

To be considered locked and therefore inaccessible:
- A room, area, cabinet, or item is locked or secured with an approved locking device. If a key or combination lock is used, the key hole or combination pad must be on the side child care is taking place.
- A key or other device used to open the lock is not in the lock.
- A safety gate is latched and secure even when bumped or shaken.
- All doors that access the same area, cupboard, closet, or cabinet are locked.

To be considered out of reach of children and therefore inaccessible:
- Items are on counters or shelves and/or in cupboards or drawers that are at least 36 inches high.
- Items are on securely stacked objects that are at least 36 inches high. To create a surface that is 36 inches or higher, stacking furniture may be used, or items may be firmly on or attached to another structure. If stacked furniture or items are unsecured they are accessible. Unsecured means loose, unbound or unattached.
- In bathrooms, items are at least 36 inches above any fixture or equipment on which a child could stand or climb, such as a toilet, bathtub, counter, stepstool, or ladder. If the fixtures have 12 inches or more between them, they will not be considered close enough for a child to move from one surface to another. Areas 36 inches above any unsecured items, such as step stools or ladders, that can be used for climbing will be considered accessible, regardless of being more than 12 inches from the fixture.

(29) "Infant" means a child who is younger than 12 months old.

Rationale/Explanation
For licensing purposes, a child is considered an infant until the child’s 1st birthday.

(30) "Infectious Disease" means an illness that is capable of being spread from one individual to
another.

(31) "Involved with Child Care" means to do any of the following at or for a child care program:
   (a) care for or supervise children;
   (b) volunteer;
   (c) own, operate, direct;
   (d) reside;
   (e) count in the caregiver-to-child ratio; or
   (f) have unsupervised contact with a child in care.

(32) "LIS Supported Finding" means background check information from the Licensing Information System (LIS) database for child abuse and neglect, maintained by the Utah Department of Human Services.

(33) "Over-the-Counter Medication" means medication that can be purchased without a written prescription including herbal remedies, vitamins, and mineral supplements.

(34) "Parent" means the parent or legal guardian of a child in care.

(35) "Physical Abuse" means causing nonaccidental physical harm to a child.

(36) "Play Equipment Platform" means a flat surface on a piece of stationary play equipment intended for more than one child to stand on, and upon which the children can move freely.

(37) "Preschooler" means a child age two through four years old.

   Rationale/Explanation
   For licensing purposes, a child is considered a preschooler on the child's 2nd birthday until the child's 5th birthday.

(38) "Provider" means the legally responsible person or business that holds a valid residential certificate from Child Care Licensing.

   Rationale/Explanation
   The provider is legally responsible for all aspects of the child care program's operation and management, and for compliance with all licensing rules.

(39) "Qualifying Child" means:
   (a) a child who is younger than 13 years old and is the child of an individual other than the child care provider or caregiver;
   (b) a child with a disability who is younger than 18 years old and is the child of an individual other than the provider or caregiver; or
   (c) a child who is younger than four years old and is the child of the provider or a caregiver.
(40) "Related Child" means a child for whom a provider is the parent, legal guardian, step-parent, grandparent, step-grandparent, great-grandparent, sibling, step-sibling, aunt, step-aunt, great-aunt, uncle, step-uncle, or great-uncle.

(41) "Residential Child Care" means care that takes place in a child care provider's home.

(42) "Sanitize" means to use a product or process to reduce contaminants and bacteria to a safe level.

(43) "School-Age Child" means a child age five through 12 years old.

Rationale/Explanation
For licensing purposes, a child is considered school age starting on the child's 5th birthday.

(44) "Sexual Abuse" means to take indecent liberties with a child with the intention to arouse or gratify the sexual desire of an individual or to cause pain or discomfort.

(45) "Sexually Explicit Material" means any depiction of actual or simulated sexually explicit conduct.

(46) "Sleeping Equipment" means a cot, mat, crib, bassinet, porta-crib, playpen, or bed.

(47) "Stationary Play Equipment" means equipment such as a climber, slide, swing, merry-go-round, or spring rocker that is meant to stay in one location when a child uses it. Stationary play equipment does not include:
(a) a sandbox;
(b) a stationary circular tricycle;
(c) a sensory table; or
(d) a playhouse that sits on the ground or floor and has no attached equipment, such as a slide, swing, or climber.

(48) "Strangulation Hazard" means something on which a child's clothes or drawstrings could become caught, or something in which a child could become entangled such as:
(a) a protruding bolt end that extends more than two threads beyond the face of the nut;
(b) hardware that forms a hook or leaves a gap or space between components such as a protruding open S-hook; or
(c) a rope, cord, or chain that is attached to a structure and is long enough to encircle a child's neck.

(49) "Toddler" means a child age 12 through 23 months old.

Rationale/Explanation
For licensing purposes, a child is considered a toddler on the child's 1st birthday and until their 2nd birthday.

(50) "Unsupervised Contact" means being with, caring for, communicating with, or touching a child in the absence of a caregiver or other employee who is at least 18 years old and has passed a Child Care Licensing background check.

(51) "Use Zone" means the area beneath and surrounding a play structure or piece of equipment that is designated for unrestricted movement around the equipment, and onto which a child falling from or exiting the equipment could be expected to land.

(52) "Volunteer" means an individual who receives no form of direct or indirect compensation for their service.

(53) "Working Days" means the days of the week the department is open for business.

Rationale/Explanation
The Department is open for business on Mondays through Fridays from 8:00 a.m. to 5:00 p.m. except on federal and state holidays.
Individuals and businesses that provide care for children are licensed and regulated by Child Care Licensing (CCL) unless they are specifically exempt under Utah law. The rules in this section explain who is required to be licensed. In licensed facilities, CCL rules apply to all qualifying children.

(1) A person shall be certified as a residential child care provider if they provide care:
   (a) In the home where they reside;
   (b) in the absence of the child's parent,
   (c) for five to 8 unrelated children,
   (d) for four or more hours a day,
   (e) for each individual child for less than 24 hours a day,
   (f) on a regularly scheduled, ongoing basis; and
   (g) for direct or indirect compensation.

Rationale/Explanation
Within the early care and education system, licensing provides the baseline of protection for children and covers the broadest content, the largest number of children from birth to school age, and the largest population of providers. Licensing helps prevent various forms of harm to children—risks from the spread of disease; fire and other building safety hazards; injury; and developmental impairment from the lack of healthy relationships with adults, adequate supervision, or developmentally appropriate activities. National Center on Early Childhood Quality Assurance. Research Brief #1: Trends in Child Care Center Licensing for 2017.

Compliance Guidelines
• An individual providing child care in their home is certified as a residential child care facility.
   - Only one license or certificate will be issued for the same home.
   - When a person owns or rents both sides of a duplex and lives in one side and wants to provide care in the other side, a license may be issued for the unoccupied side as long as there is a door adjoining both sides. In this case, the duplex will be considered one residence.
• The Utah State Legislature passed [H.B15S02](#): Child Care Amendments in the 2022 Legislative Session. Child Care Licensing is updating its rules to reflect the current law. The below compliance guidelines are in line with HB15S02.
   - A provider must be regulated by Child Care Licensing if they care for seven or more qualifying children.
   - Individuals who care for fewer than seven children are not required by law to be regulated. However, a person may request to be regulated by Child Care Licensing if they care for at least one unrelated, qualifying child under the other conditions listed in 90-3(1)(a)-(g) above.
- Individuals who care for nine or more children must apply to become a Licensed Family provider.
- People who care for children less than 4 hours per day are not required to be licensed. This includes preschools that have a morning and afternoon session, each less than 4 hours, provided that no child attends both sessions, or attends a total of 4 hours or more per day. A “regularly scheduled, ongoing basis” means that children attend the program on a regular basis, as opposed to occasional drop-in care.
- Direct compensation means that there is a cash payment for providing child care. Indirect compensation is a noncash payment of goods, time, or services for the child care that is provided.
- Noncompliance with this rule will be determined by the CCL complaint investigator.

**Risk Level**
High

**Corrective Action for 1st Instance**
Citation and CMP Warning

(2) **A person who is not required to be certified may voluntarily become certified, except for care that is for related children only or on a sporadic basis.**

**Rationale/Explanation**
When a provider cares for related children only, in order to receive child care subsidy payments from the State. Instructions for obtaining this approval may be found at: childcarelicensing.utah.gov.

A license is unavailable for occasional drop-in child care.
This section describes how to apply for a residential certificate, renew a certificate, change an existing certificate, and how to request a variance to a specific licensing rule.

**Residential Certificate Application**

(1) Each applicant for a new residential certificate shall:
   (a) submit a CCL online application;
   (b) submit a copy of a current local fire clearance or a written statement from the local fire authority that a fire inspection is not required;
   (c) submit a copy of a current local health department kitchen clearance for a facility providing food service or a written statement from the local health department that a kitchen inspection is not required;
   (d) submit a copy of a current local business license or a written statement from the city that a business license is not required;
   (e) complete CCL background checks for covered individuals as required in Section R430-50-8;
   (f) complete CCL new provider training no more than six months before becoming certified; and
   (g) pay any required fees, which are nonrefundable.

**Compliance Guidelines**

*New Provider Training and Support*

The applicant should become familiar with licensing rules and take the Department’s [New Provider Training](#) as the first steps in the application process. Specific details on how to apply for a child care license are explained in this training. CCL keeps a list of those who complete this training.

During the application period, the applicant is to create an account through [ccl.utah.gov](http://ccl.utah.gov) to receive access to their CCL provider portal. The email address used to create this account must be the email address used as their facility contact information.

**Required CCL Forms and Documents**

When applying for a child care license, the applicant must submit the following CCL-approved forms:

- [Online Application](#)
- [Background Check Form](#)

- Each covered individual must pass a CCL background check. Background checks that are run by other organizations do not meet the requirements of this rule.
To learn how to request a CCL background check, refer to: How to Submit Background Check Forms, Fingerprints, & Fees or “Section 8: Background Checks” in this manual.

Affidavit of Lawful Presence
Providers will be required to sign an Affidavit of Lawful Presence in the United States and to show the following applicable documents. This will be obtained in person, please do not submit the Affidavit of Lawful Presence or required documents.

Required Documentation United States Citizens
If you are a United States citizen, you must show the following original document(s) to CCL staff:
Option 1: a current United States Passport
Option 2: a United States birth certificate and a federal, state, or local government-issued photo ID card, such as a driver's license
Option 3: a United States Certificate of Naturalization

Qualified Aliens
If you are a qualified alien, you must show the following original document to CCL staff and have copies of the front and back of the cards for your CCL file:
Option 1: a Permanent Resident Alien Card (Green Card) or Alien Registration Receipt Card 
Option 2: a currently valid United States Employment Authorization Card

Business License, Fire and Kitchen Inspections, and Fees
To operate a business in Utah, each applicant needs to obtain a business license from the city where their child care facility will be located. Each city sets its own regulations and fees for obtaining a business license. A copy of the license must be submitted to CCL during the application period.

Child care facilities must pass a fire inspection by their local fire authority each year and pass a kitchen inspection by the local county health department to obtain a license. It is advisable for the applicant to schedule these inspections early in the application process to allow time to make any corrections ordered by the local fire or health department. Fire departments and local health departments generally charge a fee to conduct these inspections.

Utah requires the applicant to pay child care licensing fees. CCL’s fee schedule is available on CCL’s website under Payments.

(2) Each applicant shall pass a department’s inspection of the facility before a new residential certificate or a renewal is issued.

Rationale/Explanation
Licensing inspections are important to assist facilities to achieve and maintain full compliance with licensing rules. CFOC 4th ed. Standard 10.4.2.1 p.p. 442.
Compliance Guidelines
After the applicant has submitted all required documents and fees to obtain a child care license, CCL will schedule the Pre-License Inspection with the applicant. The applicant must demonstrate compliance with all licensing rules before a license will be issued. The Pre-License Inspection checklist is available under Forms and Documents. In order for a child care provider to renew their license, they must pass annual inspections verifying their compliance with licensing rules. Refer to the Introduction section of this manual for more information about annual inspections.

(3) If the local fire authority states in writing that an applicant for a new residential certificate or a renewal does not require a fire inspection, the department shall verify the applicant’s compliance with the following:
   (a) address numbers and letters shall be readable from the street;
   (b) exit doors operate properly and are well maintained;
   (c) there are no obstructions in exits, aisles, corridors, and stairways;
   (d) there is at least one unobstructed fire extinguisher on each level of the building, currently charged and serviced, and mounted not more than five feet above the floor;
   (e) there are working smoke detectors that are properly installed on each level of the building; and
   (f) boiler, mechanical, and electrical panel rooms are not used for storage.

Rationale/Explanation
The child care licensing, building, fire safety, and health authorities, as well as any other regulators (e.g., environmental, sanitation, and food safety), should work together as a team to safeguard children in child care. CFOC 4th ed. Standard 10.4.2.4 p.p. 443.

Compliance Guidelines
If the facility is not inspected by the local fire authority, a licensor will:
• Inspect the facility for compliance with this rule at the Pre-License Inspection and before the certificate renewal each year.

Refer to the following guidelines:
• Address numbers and/or letters must be readable from the street.
• Doors identified as exits must be able to open and close.
• Indoor and outdoor exits may not be blocked.
• There must be at least one all-purpose fire extinguisher in the home:
   - Caregivers should know the location of the fire extinguisher and it should be easily accessible.
   - The fire extinguisher’s seals should be intact.
   - The gauge must show that the extinguisher is charged.
• At least one well-maintained (not chirping) smoke detector is required on each level of the house.
• Storage in the boiler, mechanical, and electrical panel rooms may not block the appliance or panel.
Risk Level
Moderate
Corrective Action for 1st Instance
Citation Warning

(4) If an applicant for a new residential certificate or a renewal serves food and the local health department states in writing that a kitchen inspection is not required, the department shall verify the applicant's compliance with the following:

(a) the refrigerator is clean, in good repair, and working at or below 41 degrees Fahrenheit;
(b) there is a working thermometer in the refrigerator;
(c) there is a working stem thermometer available to check cooking and hot hold temperatures;
(d) reusable food holders, utensils, and food preparation surfaces are washed, rinsed, and sanitized before each use;
(e) chemicals are stored away from food and food service items;
(f) food is properly stored, kept to the proper temperature, and in good condition; and
(g) there is a working handwashing sink in the kitchen.

Rationale/Explanation
Inspectors from state and local agencies with appropriate training should check food service equipment and provide technical assistance to facilities. The local public health department typically conducts such inspections. Local health department regulations for food safety are based on scientific data about the conditions required to prevent contamination of food with infectious or toxic substances that cause foodborne illness. CFOC 3 ed. Standard 1.4.5.1 p.p. 30; Standard 4.8.0.2 p.p. 186; Standard 4.9.0.1 p.p. 188.

Compliance Guidelines
The child care facility must have a kitchen inspection if food for the children is prepared at the facility. A kitchen inspection is not required if 1) all food is brought by parents for their own children, 2) the food is prepared in another inspected kitchen and then brought to the facility to be served, or 3) the only food preparation is that of preparing baby bottles or baby food.

The following guidelines apply in the assessment of this rule:
• The refrigerator should be free of a buildup of spills, dirt, and grime.
• Chemicals must be stored at least 3 feet away from food and food service items, or separated by a solid barrier.
• Food should show no signs of spoilage, such as mold or obvious rancid smells.
(5) Each applicant shall have six months from the time any portion of the application is submitted to finish the residential certificate process. If unsuccessful, the applicant shall reapply. Any resubmission must include the required documentation, payment of certification fees, and a new inspection of the facility to be certified.

(6) The department may deny an application for a residential certificate if, within the five years preceding the application date, the applicant held a license or a residential certificate that was:
   (a) closed under an immediate closure;
   (b) revoked;
   (c) closed as a result of a settlement agreement resulting from a notice of intent to revoke, a notice of revocation, or a notice of immediate closure;
   (d) voluntarily closed after an inspection of the facility found rule violations that would have resulted in a notice of intent to revoke or a notice of revocation had the provider not closed voluntarily; or
   (e) voluntarily closed having unpaid fees or civil money penalties issued by the department.

(7) Each child care residential certificate expires at midnight on the last day of the month shown on the residential certificate, unless the residential certificate was previously revoked by the department, or voluntarily closed by the provider.

Certificate Renewal

(8) Within 30 to 90 days before a current residential certificate expires, each provider shall submit for renewal:
   (a) an online renewal request;
   (b) applicable renewal fees;
   (c) any previous unpaid fees; and
   (d) a copy of a current fire inspection report.

Compliance Guidelines
As part of the certificate renewal process, the facility must pass an inspection by:
   • The local fire authority; or pass an inspection by CCL that verifies compliance with 50-4(3) if the local fire authority states that a fire inspection is not required.

(9) The department may grant a provider who fails to renew their residential certificate by the expiration date an additional 30 days to complete the renewal process if the provider pays a late fee.

Compliance Guidelines
A provider may choose not to renew their child care license or they may voluntarily close their child care facility, pay all pending fees, and relinquish their license at any time. However, all
licensing rules must be in compliance and all licensing procedures (such as inspections, background checks, and fees) will continue until the facility closes and the provider no longer cares for children.

(10) The department may deny renewal of a residential certificate for a provider who is no longer caring for children.

Compliance Guidelines
The provider's child care certificate will be closed on the day they are no longer caring for children, or if the child care facility is found vacant.

Certificate Changes

(11) Each provider shall submit a complete application for a new residential certificate at least 30 days before a change of the child care facility's location.

Compliance Guidelines
If a provider will be changing the location of their facility, they may begin the application process, but may not care for children at the new location until their new certificate has been approved.

For a change of location, the provider must submit the following to CCL:
- An online application for a new child care certificate;
- A copy of a current local fire clearance or a statement from the local fire authority that a fire inspection is not required for the new facility;
- A copy of a current local health department kitchen clearance or a statement from the local health department that a kitchen inspection is not required for the new facility;
- A copy of a current local business license or a statement from the city that a business license is not required; and
- All required fees, which are nonrefundable.

The following submissions are not required for a change of location:
- CCL background checks if they are current for all covered individuals as required in rule;
- A signed Affidavit of Lawful Presence form provided by the department; and
- A copy of the department’s new provider training certificate of attendance.

(12) A provider shall submit a complete online changes request to amend an existing residential certificate at least 30 days before any of the following changes:
(a) an increase or decrease of residential certificate capacity, including any change to the amount of usable indoor space where child care is provided;
(b) a change in the name of the program;
(c) a change in the regulation type of the program;
(d) a change in the name of the provider; or
(e) a transfer of business ownership.
Compliance Guidelines
• Apply for a license change through the Child Care Licensing Portal
• A CCL fee is charged if the provider makes more than 2 license changes per licensing year.

Risk Level
Low
Corrective Action for 1st Instance
Warning

(13) The department may amend a residential certificate after verifying that the applicant is in compliance with all applicable rules and required fees have been paid. The expiration date of the amended residential certificate remains the same as the previous residential certificate.

(14) Only the department may assign, transfer, or amend a residential certificate.

Compliance Guidelines
• The provider must operate under their own certificate issued by the department.
• The provider must not alter the license in any way or for any reason.

Risk Level
High
Corrective Action for 1st Instance
Citation and CMP Warning

Rule Variances

(15) If an applicant or provider cannot comply with a rule but can meet the intent of the rule in another way, they may apply for a variance to that rule by submitting a request to the department.

Compliance Guidelines
The provider may submit a variance request online through their Child Care Licensing portal.

(16) Each provider shall comply with the existing rules until a variance is approved by the department.

(17) If a variance is approved, the provider shall keep a copy of the written approval on-site for review by parents and the department

Compliance Guidelines
• An electronic copy of the variance approval is acceptable as long as it is available on-site for review by parents and CCL staff.
Risk Level
Low
Corrective Action for 1st Instance
Warning

(18) The department may grant variances for up to 12 months.

Compliance Guidelines
Providers must reapply for variances annually as needed.

(19) The department may revoke a variance if:
(a) the provider is not meeting the intent of the rule as stated in their approved variance;
(b) the provider fails to comply with the conditions of the variance; or
(c) a change in statute, rule, or case law affects the basis for the variance.
This section gives information about rule violations and penalties for noncompliance with rules. The first part of this section lists the rules; the last part describes the CCL enforcement process including the use of penalties for rule violations.

**Rationale/Explanation**
The National Association for the Education of Young Children (NAEYC) supports the position that each state has the responsibility to regulate child care facilities. Penalties should be a part of the state's regulations to give strength to licensing rules. Research shows that states with the most effective regulation have a greater number of higher quality child care programs. NAEYC. (1998). Licensing and Public Regulation of Early Childhood Programs. Washington, DC.

1. The department may place a program's child care residential certificate on a conditional status for the following causes:
   - (a) chronic, ongoing noncompliance with rules;
   - (b) unpaid fees; or
   - (c) a serious rule violation that places children's health or safety in immediate jeopardy.

2. The department shall establish the length of the conditional status and set the conditions that the child care provider shall satisfy to remove the conditional status.

3. The department may increase monitoring of the program that is on conditional status to verify compliance with rules.

4. The department may deny or revoke a residential certificate if the child care provider:
   - (a) fails to meet the conditions of a residential certificate on conditional status;
   - (b) violates the Child Care Licensing Act;
   - (c) provides false or misleading information to the department;
   - (d) misrepresents information by intentionally altering a residential certificate or any other document issued by the department;
   - (e) fails to allow authorized representatives of the department access to the facility to ensure compliance with this rule;
   - (f) fails to submit or make available to the department any written documentation required to verify compliance with this rule;
   - (g) commits a serious rule violation that results in death or serious harm to a child, or that places a child at risk of death or serious harm; or
   - (h) has committed an illegal act that would exclude a person from having a residential certificate.
(5) Within ten working days of receipt of a revocation notice, the provider shall submit to the department the names and mailing addresses of the parents of each enrolled child so the department can notify the parents of the revocation.

(6) The department may order the immediate closure of a facility if conditions create a clear and present danger to any child in care and may require immediate action to protect the children’s health or safety.

(7) Upon receipt of an immediate closure notice, the provider shall give the department the names and mailing addresses of the parents of each enrolled child so the department can notify the parents of the immediate closure.

(8) If there is a severe injury or the death of a child in care, the department may order a child care provider to suspend services and prohibit new enrollments, pending a review by the Child Fatality Review Committee or a determination of the probable cause of death or injury by a medical professional.

(9) If a person is providing care for more than four unrelated children without the appropriate license, the department may:
   (a) issue a cease and desist order, or
   (b) allow the person to continue operation if:
      (i) the person was unaware of the need for a license,
      (ii) conditions do not create a clear and present danger to the children in care, and
      (iii) the person agrees to apply for the appropriate license or residential certificate within 30 calendar days of notification by the department.

(10) If a person providing care without the appropriate license agrees to apply for a license but does not submit an application and all required application documents within 30 days, the department may issue a cease and desist order.

(11) A violation of any rule is punishable by an administrative civil money penalty of up to $5,000 a day as provided in Section 26-39-601.

(12) The department may assess a civil money penalty and also take action to deny, place on conditional status, revoke, immediately close, or refuse to renew a residential certificate.

(13) The department may deny an application or revoke a residential certificate for failure to pay any required fees, including fees for applications, late fees, returned checks, license changes, additional inspections, conditional monitoring inspections, background checks,
civil money penalties, and other fees assessed by the department.

(14) An applicant or provider may request a hearing to appeal any department decision within 15 working days of being informed in writing of the decision.

CHILD CARE LICENSING ENFORCEMENT PROCESS

Prevention Strategies

CCL takes several preventive steps to encourage compliance with licensing rules before more restrictive actions are needed. CCL offers:

• Technical assistance before licensing
• New provider training
• Verbal technical assistance before, during, and after inspections
• Training on the licensing process and rules for those involved with child care
• A website with up-to-date resources and announcements
• Access to CCL trainers, licensors, management, and support staff
• Support and updates from community partners, such as Care About Childcare
• Information about any licensing changes

Child Care Licensing Inspections

CCL conducts regular inspections of child care programs to determine if providers are in compliance with the state's licensing rules. This is critical in ensuring that regulations are enforced. During these inspections, licensing staff may find instances of rule violations. When a facility is found to be out of compliance, CCL is legally responsible for taking corrective action so that problems are resolved quickly before they become serious. This is usually handled by the provider agreeing to make necessary corrections within a specified amount of time. Some violations may be corrected on-site during the inspection while others may take longer to correct. Serious rule violations that may place the children at immediate risk must be corrected before the licensor leaves the facility. CCL staff will conduct a Follow-up Inspection to verify that any rule violations are corrected, that compliance is maintained, and to ensure that there are no new, serious rule violations. If more than one Follow-up Inspection is required to ensure compliance with rules, a fee of $25.00 (as set by the Utah State Legislature) is charged for each additional Follow-up Inspection.

Risk Assessment

Risk assessment is a method of identifying the possibility and severity of harm that may result from a rule violation. Harm is physical, emotional, or psychological injury to a child. Any noncompliance with rule poses a level of risk or harm to children. However, some instances of rule violations present significantly more risk.
The National Association for Regulatory Administration (NARA) advises that licensing agencies maintain research-based assessment methods where risks are prioritized; inspections and technical assistance are focused accordingly; and corrective actions are systematically applied to build consistent compliance. NARA. Recommended Best Practices for Human Care Regulatory Agencies. Lexington, KY. (2009).

CCL’s risk assessment has identified the following four levels of risk or harm that may result from a rule violation. Each level is based on actual or potential harm and the severity of the harm.

- **Low risk or harm** – Harm has not occurred, and is not likely to occur, but the possibility of harm exists.
- **Moderate risk or harm** – Harm that does not require intervention from a medical or mental health care provider has already occurred, or is likely to occur.
- **High risk or harm** – Harm that requires intervention from a medical or mental health care provider has already occurred, or is likely to occur.
- **Extreme risk or harm** – Harm including death or life-threatening injury has already occurred or is likely to occur.

**Corrective Actions**

CCL’s enforcement of licensing rules can be viewed as a progressive set of steps. Utah statute and rules require that when a provider has a serious rule violation, has frequent violations, and/or fails to correct a deficiency, CCL must take corrective action. This is a process of communicating with the provider and taking disciplinary action to ensure the provider comes into compliance with rules.

In determining what action to take, CCL considers several factors:

- Whether actual harm has come to children,
- The risk of harm,
- The scope and severity of each violation, and
- Whether or not it is the first instance of a violation.

CCL uses the following corrective actions to ensure compliance with licensing rules.

**Warning**

This action warns the provider that a Low Risk rule violation must be corrected within a specified amount of time. The Warning is documented by CCL, but is not displayed on the provider’s public record.

**Citation Warning**

This action alerts the provider that a repeat instance of a rule violation will be a Citation. A Citation Warning is documented in CCL’s software program (the CCL App), but is not displayed on the provider’s public record.

**Citation and CMP Warning**

A Citation is issued for serious or repeat rule violations along with a warning that another instance of the rule violation will result in a civil money penalty (CMP).
A Citation and CMP Warning is not only documented by CCL, but is displayed on the provider’s public record because of the serious nature of the rule violation.

- A child care provider's public record is available on the CCL website for 36 months.
- All rule violations substantiated in a complaint investigation are public record.
- To check a provider's public record that is older than 36 months, the public may contact CCL.

Repeat Citation and CMP
If a cited rule violation reoccurs, a Repeat Citation is issued and a CMP is imposed. This corrective action is placed on the provider’s public record.

Citations and Repeat Citations are each assigned 10 Citation points. CCL uses these points in a system to track a provider's noncompliance with the rules and to alert CCL before a facility reaches a critical noncompliant state. This system is maintained in the CCL App and is not made available to the public.

Plan of Correction
If a provider accumulates 150 Citation tracking points within a 36-month period, CCL will require that the provider follow a Plan of Correction. The Plan will help move the provider toward compliance while allowing them (in most cases) to continue to provide child care and avoid being placed on a conditional residential certificate.

Usually, the provider, licensor, and region manager will discuss and develop the Plan including:

- Rule violations that will need to be corrected,
- Conditions the provider must meet,
- Amount of time that will be allowed for the provider to come in to compliance, and
- Corrective actions that will be taken by CCL if the provider fails to comply with the conditions of the Plan, including placing the provider's residential certificate on Conditional status.

There may not be more than one Plan of Correction in a 36-month period.

Conditional Certificate
A severe rule violation, a violation of any of the conditions described in a Plan of Correction, or failure to meet the deadlines described in the Plan may place a provider's child care certificate on a conditional status. In order for the provider to keep their child care certificate, they must come into compliance within a specified amount of time. CCL staff will conduct monitoring inspections to verify that this occurs.

Depending on the severity of the rule violations and as outlined in the Plan of Correction, the required Monitoring Inspections may be frequent when the provider's certificate is placed on conditional status. The Plan of Correction will state whether weekly, semimonthly, or monthly Monitoring Inspections will be conducted. As set by the Utah State Legislature, an inspection fee of $245.00 is charged for each Monitoring Inspection. The Plan of Correction will also indicate how long the conditional status will last and what will be required for the provider to regain regular certificate status.
Other Corrective Actions
Recurring and/or severe rule violations can lead to other corrective actions such as an Intent to Revoke, Revocation, and Immediate Closure.

A Warning Letter is used to warn the provider that their certificate will be revoked if the issue(s) described in the Warning Letter letter is not corrected by the specified date.

A Revocation letter is used to inform the provider that their certificate has been revoked. This letter will also state the reason(s) for the revocation. Refer to 50-5(4) for violations that may result in a certificate being revoked.

An Immediate Closure is enforced when the department determines that the children's well-being is at risk and the child care facility must be closed immediately. When this happens, CCL staff will arrive at the facility, notify the parents of each enrolled child of the closure, and remain at the facility until all the children have been picked up by their parents or persons authorized to do so. A Follow-up Inspection will also be conducted to verify that the provider is not in business after having been closed by the department.

The department may also deny a certificate if a provider has been previously closed by CCL.

Corrective Action Grid
The following chart summarizes rule violation risk levels and the corresponding corrective actions. The first column describes the levels of risk (moving down the column) from Low to Extreme risk. The possible corrective actions are listed horizontally across the top of the chart ranging from least to most stringent. A CCL corrective action is based on the degree of risk or harm and the number of instances a rule violation has occurred. For example, the corrective action for the 1st instance of a Low Risk rule violation would be a Warning. If there was a 2nd instance of that same rule violation, the provider would receive a Citation Warning. For the 1st instance of a rule violation with Extreme risk or harm, a Citation and a CMP would be issued with the possibility of other corrective actions being enforced.

<table>
<thead>
<tr>
<th>Corrective Action</th>
<th>Warning</th>
<th>Citation Warning</th>
<th>Citation &amp; CMP Warning</th>
<th>Repeat Citation &amp; CMP &amp; Possible: Plan of Correction, Conditional, Intent to Revoke, or Revocation</th>
<th>Citation &amp; CMP &amp; Possible: Plan of Correction, Conditional, Intent to Revoke, Revocation, Immediate Closure</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Risk or Harm</strong></td>
<td>On CCL Record Only</td>
<td>On Public Record</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low</td>
<td>1st Instance</td>
<td>2nd Instance</td>
<td>3rd Instance</td>
<td>4th Instance</td>
<td>5th Instance</td>
</tr>
<tr>
<td>-----</td>
<td>--------------</td>
<td>--------------</td>
<td>--------------</td>
<td>--------------</td>
<td>--------------</td>
</tr>
<tr>
<td>Moderate</td>
<td>→ 1st Instance</td>
<td>2nd Instance</td>
<td>3rd Instance</td>
<td>4th Instance</td>
<td></td>
</tr>
<tr>
<td>High</td>
<td>→ 1st Instance</td>
<td>2nd Instance</td>
<td>3rd Instance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Extreme</td>
<td>→ 1st Instance</td>
<td>2nd Instance</td>
<td>3rd Instance</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The corrective action will not be reduced for the following rule violations:
- High or Extreme harm to a child
- Inappropriate interactions with children
- Lack of supervision
- An infant sleeping in unsafe equipment
- Inappropriate caregiver-to-child ratio
- No background check for a new covered individual
- An accessible firearm
- Intoxication or impairment of provider or caregiver when a child is in care
- Use of tobacco or similar product, alcohol, or an illegal substance when a child is in care

Civil Money Penalty (CMP)
A Civil Money Penalty (CMP) is a fine charged by the Department for Repeat Citations, or when the first instance of a rule violation results in or is likely to result in Extreme risk or harm.

<table>
<thead>
<tr>
<th>CMP Amounts for Repeat Citations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low Risk Repeat Citation ... $100 per area per rule</td>
</tr>
<tr>
<td>Low Risk Supervision or Ratio Repeat Citation ... $100 per child unsupervised or over ratio</td>
</tr>
<tr>
<td>Low Risk Background Check Repeat Citation ... $100 per individual out of compliance</td>
</tr>
<tr>
<td>Moderate Risk Repeat Citation ... $150 per area per rule</td>
</tr>
<tr>
<td>Moderate Risk Supervision or Ratio Repeat Citation ... $150 per child unsupervised or over ratio</td>
</tr>
</tbody>
</table>
Due to Extreme risk or harm, a Citation and CMP will immediately be issued for the first instance of the following rule violations.

<table>
<thead>
<tr>
<th>Immediate CMP Amounts for Extreme Risk Rule Violations</th>
</tr>
</thead>
<tbody>
<tr>
<td>- A child leaves the facility without supervision ............... $500 CMP</td>
</tr>
<tr>
<td>- A child is left outside of the facility or in a vehicle without supervision ................ $500 CMP</td>
</tr>
<tr>
<td>- An individual who failed to pass a CCL background check is at the facility ........... $500 CMP</td>
</tr>
<tr>
<td>- A provider submitted or allowed falsified documents to be submitted to CCL ........ $500 CMP</td>
</tr>
<tr>
<td>- An accessible firearm (does not apply to a firearm that is unlocked, but inaccessible). . $500 CMP</td>
</tr>
<tr>
<td>- A child suffered serious harm as the result of a rule violation ................ $1,200 CMP</td>
</tr>
<tr>
<td>- The death of a child was the result of a rule violation .......................... $5,000 CMP</td>
</tr>
</tbody>
</table>

If a rule violation resulted in a CMP and there is a repeat instance of the rule violation within a 36-month period, the CMP will be double the amount of the original CMP (and all subsequent CMPs will be issued at the doubled amount) not to exceed $5,000.

A CMP must be paid no later than 30 days from the notification date.

**Action Reviews (Appeals)**

The term “appeal” is a legal term. To prevent confusion with the legal process, CCL will now refer to appeals as an “Action Review.”

There are three levels of Action Reviews, a provider may choose to start the action review at any level:
- Level 1 is a “Management review.” This will be held with the licensor’s supervisor.
- Level 2 is an “Informal Discussion.” This can be held with the CCL Administrator, the Bureau Director, or Division Director.
- Level 3 is an “Informal Hearing.” This can be held with a representative from the Executive Director’s office or an Administrative Law Judge.

It is a “Formal Appeal” if a provider chooses to use the legal system through an Administrative Law Judge or the courts for dispute resolution. This is handled by the lawyers, not CCL.

Providers are encouraged to ask CCL for clarification about its processes and decisions. Having a clear understanding of CCL’s actions will be most beneficial and can help the provider determine if an action review is necessary.
Providers have 15 working days to request a review of any action taken by CCL. The action review period begins on the date that the provider receives official notification of a CCL action, such as receipt of an Inspection Report.

To request an action review, the provider must submit a written action review request through the provider’s Child Care Licensing portal.

Action reviews conducted by the department and CCL staff are considered informal discussions and the department will not charge a fee. CCL will schedule the time to hear the provider’s informal action review. This action review session may be conducted by phone, in person at a CCL office, or at the provider's facility depending on the availability of all involved parties.

The department may include any licensors involved in the inspection where rule violations are being reviewed, and any other necessary staff.

The provider may choose the level of authority to begin the action review process, however, the action review process cannot move to an appeal officer with a lower authority once a decision has been made.

<table>
<thead>
<tr>
<th>Action Review Officer Hierarchy</th>
<th>Level of Action Review</th>
</tr>
</thead>
<tbody>
<tr>
<td>CCL Team Manager</td>
<td>Management Review</td>
</tr>
<tr>
<td>CCL Administrator</td>
<td>Informal Discussion</td>
</tr>
<tr>
<td>Bureau Director</td>
<td>Informal Discussion</td>
</tr>
<tr>
<td>Division Director</td>
<td>Informal Discussion</td>
</tr>
<tr>
<td>Internal Administrative Law Judge</td>
<td>Informal Hearing</td>
</tr>
<tr>
<td>Department Executive Director</td>
<td>Informal Hearing</td>
</tr>
<tr>
<td>Administrative Law Judge</td>
<td>Formal Appeal</td>
</tr>
<tr>
<td>Courts</td>
<td>Formal Appeal</td>
</tr>
</tbody>
</table>

If a provider retains legal counsel or decides to make a formal appeal with an Administrative Law Judge or through the courts, it will be the responsibility of the provider to pay all costs associated with the action review.

Providers are welcome to present any documentation, witness statements, and other evidence, or to bring witnesses if they consider it necessary to support their action review.
In some cases, the provider may choose to retain legal advice and to have their attorney be present at an action review session. In this case, the provider must notify CCL of their intent to bring their attorney so the department’s attorney may also be present. Otherwise, the action review session will be canceled and rescheduled when all parties, including both attorneys, can be present.

During the action review process, rule violations being reviewed will not show on the provider’s public record, and reviewed CMP penalties will not be enforced until the action review is resolved. However, the provider will continue to receive routine inspections, including Follow-up Inspections, for all other rule violations and the provider must maintain compliance with licensing rules while the action review is being resolved.

After the action review process is over, the provider will receive written notification of the action reviews outcome and the facility’s file in the CCL App (CCL’s software program) will be updated accordingly. The results of the action review process may be that the rule violations are upheld (not removed from the record) or rescinded (removed from the record). Additionally, the corrective action for the rule violation may be changed as part of the action review outcome.

If the provider is not satisfied with the outcome of an action review, they may appeal with a higher departmental authority within 15 working days after receiving the action review outcome notification.
This section explains the rules dealing with the provider’s responsibilities in operating and managing a child care facility. It also details the rules regarding children’s records.

**Administration**

1. **The provider shall:**
   a. be at least 18 years old;
   b. be deemed eligible by a CCL background check before becoming involved with child care;
   c. complete the new provider training offered by the department; and
   d. complete at least 10 hours of child care training each year, based on the facility’s residential certificate date.

**Compliance Guidelines**

**Background Checks**

The provider must pass a CCL background check.
- Background checks that are processed by other organizations do not meet the requirements of this rule.
- Instructions for requesting a CCL background check are found at: “How to Submit Background Check Forms, Fingerprints, & Fees” or in “Section 8: Background Checks” in the Interpretation Manual.

**Training**

Complete the New Provider training under Free Training for Providers and Caregivers.

2. **The provider shall protect children from conduct that endangers children in care, or is contrary to the health, morals, welfare, and safety of the public.**

**Rationale/Explanation**

Child care staff members are important figures in the lives of the young children in their care and in the well-being of families and the community. CFOC 4th ed. Standard 1.4.2.1 p.p. 23.

**Compliance Guidelines**

This rule will be considered out of compliance if:
- A child’s well-being has been jeopardized or the provider’s conduct is contrary to the health, morals, welfare, and safety of the public; and
- There is no other licensing rule that specifically addresses the situation.

Examples of noncompliance include:
• Evidence of committing, aiding, abetting, or permitting the commission of any illegal act.
• The caregiver leaves the room while an infant is on an elevated surface, such as a couch or bed.
• In the event of a public emergency, the provider shall follow conditions put in place by the department.

**Corrective Action for 1st Instance**
The corrective action will be based on the severity of harm that was caused or likely to be caused as a result of a rule violation.

**Corrective Action for 1st Instance**
The corrective action will be based on the severity of harm that was caused or likely to be caused as a result of a rule violation.

(3) **The provider shall know and comply with each applicable federal, state, and local law, ordinance, and rule, and shall be responsible for the operation and management of a child care program.**

**Compliance Guidelines**
• The Americans with Disabilities Act (ADA) is a federal civil rights law that prohibits discrimination against people with disabilities. For information about ADA requirements, refer to: [www.ada.gov](http://www.ada.gov).
• If a law or rule from one agency conflicts with the law or rule of another, the provider must follow the stricter of the two regulations.

This rule will be considered out of compliance if:
• There is a violation of federal, state, or local law or another agency's regulation regarding child care; and
• There is no other licensing rule that specifically addresses the violation.

**Corrective Action for 1st Instance**
The corrective action will be based on the severity of harm that was caused or likely to be caused as a result of a rule violation.

(4) **The provider shall comply with licensing rules any time a child in care is present.**

**Rationale/Explanation**
It is a legal requirement that any time a child in care is present, the provider must be in compliance with licensing rules. This includes care provided at the facility by anyone at any time, and care provided at any other location.

A qualifying child (both related and unrelated) is considered a child in care when the provider receives direct or indirect compensation in return for providing child care. Compensation includes food program reimbursements and child care subsidy payments.

**Compliance Guidelines**
The provider is ultimately responsible for compliance with licensing rules whenever a child is in care at the facility or offsite. This means the provider is responsible for every decision made and action taken by any person involved with the child care program. This is the case:
• Whether or not the provider is present,
• Even when the provider has delegated specific responsibilities to another individual, and • Even if someone else disregards or violates a licensing rule while children are in care.

Corrective Action for 1st Instance
The corrective action will be based on the severity of harm that was caused or likely to be caused as a result of a rule violation.

(5) The provider shall post their unaltered child care residential certificate on the facility premises in a place readily visible and accessible to the public during business hours.

Rationale/Explanation
Each local and/or state regulatory agency gives official permission to certain persons to operate child care programs by virtue of their compliance with regulations. Therefore, documents relating to investigations, inspections, and approval to operate should be made available to consumers, caregivers/teachers, concerned persons, and the community. CFOC 4th ed. Standard 9.4.1.6 p.p. 410-411.

Compliance Guidelines
• The child care certificate must be readily visible and accessible to parents, the department staff, and other members of the public who may visit the facility.
• The certificate must be posted during business hours. It is not required to be posted outside of business hours.

Risk Level
Low
Corrective Action for 1st Instance
Warning

(6) The provider shall post a current copy of the department's Parent Guide at the facility for parent review during business hours or give a current copy to each parent.

Rationale/Explanation
The telephone number, email address, or other contact method for filing complaints should be listed on material about licensing that is given to parents/guardians by the state licensing agency and the resource and referral agency. CFOC 4th ed. Standard 10.4.3.1 p.p. 443.

Compliance Guidelines
• The provider must use the current version of the department's Parent Guide found on the CCL website under Forms and Documents.
• If posted, the Parent Guide must be located where parents can review it as they come and go.
• If not posted, the Parent Guide must be given to each parent upon enrollment and each time it is updated.
(7) The provider shall inform parents and the department of any changes to the program’s telephone number and other contact information within 48 hours of the change.

Compliance Guidelines
To be in compliance, the provider must inform parents and CCL of any changes to the following information:
- The facility’s telephone number and email address.
- The provider’s (or contact person’s) name, email address, and telephone number.

(8) The provider shall:
- (a) have liability insurance, or
- (b) inform parents in writing that the provider does not have liability insurance.

Rationale/Explanation
The liability insurance should include coverage for administration of medications, as well as for unintentional injuries and illnesses. CFOC 4th ed. Standard 9.4.1.1 p.p. 407.

Compliance Guidelines
The provider may use any written format to inform parents if the facility does not have liability insurance.

(9) The provider shall ensure that a parent completes an admission and health assessment form for their child before the child is admitted into the child care program.

Rationale/Explanation
The health and safety of individual children requires that information regarding each child in care be kept and made available on a need-to-know basis. CFOC 4th ed. Standard 9.4.2.1 p.p. 418.
Compliance Guidelines
• Before providing care for a child, the provider must have an admission and health assessment form completed by the child's parent.
• The provider must also have a completed admission and health form for the provider's and employees' own children younger than 4 years old and any drop-in children.
• Parents may list more than one child on an admission form, but must complete a separate health assessment for each child.

Risk Level
Moderate
Corrective Action for 1st Instance
Citation Warning

(10) The provider shall ensure that each child's admission and health assessment form includes the following information:
(a) child's name;
(b) child's date of birth;
(c) parent's name, address, and phone number, including a daytime phone number;
(d) names of individuals authorized by the parent to sign the child out from the facility;
(e) name, address, and phone number of an individual to be contacted if an emergency happens and the provider cannot contact the parent;
(f) if available, the name, address, and phone number of an out-of-area emergency contact individual for the child;
(g) parent's permission for emergency transportation and emergency medical treatment;
(h) any known allergies of the child;
(i) any known food sensitivities of the child;
(j) any chronic medical conditions that the child may have;
(k) instructions for special or nonroutine daily health care of the child;
(l) current ongoing medications that the child may be taking; and
(m) any other special health instructions for the caregiver.

Rationale/Explanation
The information on the admission and health assessment form is necessary to protect the health and safety of children in care. Admission of children without this information can leave the staff unprepared to manage children's daily and emergent health needs. For example:
• Names of individuals authorized to pick children up are needed to prevent children from being taken by unauthorized individuals.
• Emergency treatment consent is needed in order to obtain medical care for children in emergencies.
• Food sensitivities and allergies are common in infants and children, and staff should know in advance whether a child has a food sensitivity or allergy. Deaths from food allergies are

**Compliance Guidelines**
- The provider may use the CCL-approved admission and health assessment form, or they may use their own program's form as long as there is a place to document all of the information required in rule.
- The CCL-approved admission and health assessment form is found on the CCL website in the "**Forms and Documents**" section.
- Forms and documents may be printed out or kept electronically.

**Risk Level**
Moderate

**Corrective Action for 1st Instance**
Citation Warning when the form does not ask for the following information:
- Child's name
- Child's date of birth
- Parent's name, address, and phone number, including a daytime phone number
- Current emergency medical treatment and emergency transportation releases with the parent's signature
- Any known allergies of the child
- Any medical conditions that the child may have

**Risk Level**
Low

**Corrective Action for 1st Instance**
Warning when the form asks for the above information, but does not request the following:
- Names of people authorized by the parent to sign the child out from the facility
- Unless there is a court order prohibiting it, parents whose names are not listed can pick up their children.
- Name, address, and phone number of a person to be contacted in case of an emergency if the provider is unable to contact the parent
- Name, address, and phone number of an out-of-area emergency contact person for the child
- Any known food sensitivities of the child
- Instructions for special or nonroutine daily health care of the child
- Current ongoing medications that the child may be taking
- Any other special health instructions for the caregiver

(11) The provider shall ensure that the admission and health assessment form is:
- (a) reviewed, updated, and signed or initialed by the parent at least annually; and
- (b) kept on-site for review by the department.

**Rationale/Explanation**
The facility should ask parents/guardians for information regarding the child's health, nutrition, level of physical activity, and behavioral status upon registration or when there has been an extended gap in the child's attendance at the facility. The child's health record should be updated if they have had any changes in their health or immunization status. CFOC 4th ed. Standard 2.3.3.1 p.p. 84-85.

**Compliance Guidelines**

- If the admission information and health assessment is one form (either one sheet of paper or multiple attached papers), the parent's signature and date may be on one page of the form.
  - Attached papers means they are in the same file, in a sleeve, behind the same tab in a notebook, etc.
- Parents or guardians must be presented with the admission and health assessment form once every twelve months and offered a means to make changes or updates to the forms as needed.
- If the admission information and health assessment are on separate, unattached papers, the parent's signature and date must be on each form.
- If the provider uses electronic admission and health assessment forms, there should be a back-up plan for accessing the children's information in case of a power failure or there is no internet service.
- Forms and documents may be printed out or kept electronically.
- Electronic signatures are accepted

**Risk Level**
Moderate

**Corrective Action for 1st Instance**
Citation Warning

(12) Before admitting any child younger than five years old into the child care program, including the provider's and employees' own children, the provider shall get the following documentation from the child's parent:

(a) current immunizations;
(b) a medical schedule to receive required immunizations;
(c) a legal exemption; or
(d) a 90-day exemption for children who are homeless.

**Rationale/Explanation**
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. CFOC 4th ed. Standards 7.2.0.1, 7.2.0.2 p.p. 317-318.

**Compliance Guidelines**
- A provider may admit a child into the child care program, but may not begin caring for the child before the requirements of this rule are met.
• Children in foster care may also have a 90 exemption for having documentation of current immunizations.

**Immunization Requirements**
For information about required immunizations for children enrolled in a child care program, refer to the “School & Early Childhood Program Requirements” section of the Utah Department of Health Immunization Program.

**Medical Schedule**
According to Utah law (R396-100-7), a child care provider may conditionally enroll a child who is not appropriately immunized as long as the child has received at least one dose of each required vaccine and is on a catch-up schedule. If the immunization schedule falls more than one month behind, the provider must immediately exclude the child from the child care program.

**Documentation**
According to Immunization Rule R396-100, providers must document children’s immunizations by:
• Using the official Utah School Immunization Record (USIR or pink form);
• Accepting any immunization record provided by a licensed physician, registered nurse, or public health official and transferring the information to the USIR (pink form); or
• Keeping immunization records in the Utah Statewide Immunization Information System (USIIS).

If a child is exempt from being immunized, the provider must keep a copy of the child’s official immunization exemption form (attached to the Utah School Immunization Record) and other required exemption documents in the child’s file.

**Exemption from Vaccination**
Parents must use an official immunization exemption form to exclude their child from being immunized and present the form to the child care provider. An exemption form can be obtained by completing an online education module (free of charge) and then printing the vaccination exemption form. It can also be obtained through an in-person consultation at the local health department (a fee may apply) where it will be signed.

For a medical exemption from vaccination, the child's parent must give the child care provider the completed immunization exemption form as well as a note signed by a licensed healthcare professional. The note must state that due to the physical condition of the child, administration of the vaccine would endanger the child’s life or health.

For an exemption from vaccination due to a child’s immunity to a disease (the child previously had the disease), the parent must submit a document signed by a healthcare provider to the child care provider as proof of immunity.

**90-Day Exemption**
The McKinney-Vento Act allows 90 days from enrollment for families who are experiencing homelessness to provide the required immunization records. A written statement that the family is homeless is adequate documentation for this 90-day exemption. More information is available in Care About Chilcare's resource: [Homeless Children in Care](#).

**Risk Level**
Moderate

**Corrective Action for 1st Instance**
Citation Warning

(13) For each child younger than five years old, including the provider's and employees' own children, the provider shall keep their current immunization records on-site for review by the department.

**Rationale/Explanation**
A representative of the department or the local health department may examine, audit, and verify immunization records maintained by any school or early childhood program.

**Compliance Guidelines**
Immunization records may be in hardcopy or kept electronically.

**Risk Level**
Low

**Corrective Action for 1st Instance**
Warning

(14) The provider shall submit the annual immunization report to the Immunization Program in the Utah Department of Health by the date specified by the department.

**Rationale/Explanation**
Immunizations are an important part of our children's healthcare. The [Utah Immunization Rule for Students, Rule 396-100](#), requires that children attending school or childcare facilities be vaccinated against certain vaccine-preventable diseases. State law requires that unless for personal, medical, or religious exemptions, a student may not attend a public, private, or parochial kindergarten, elementary, or secondary school though grade 12, or early childhood programs, including nursery or preschools, licensed daycare centers, childcare facilities, family home care facilities, and Head Start Programs. State law also requires that schools and early childhood programs collect immunization information and report immunization data annually. Data is collected to determine which schools and childcare facilities are in compliance with state law and to determine how many children are adequately immunized (School & Early Childhood Program Immunization Reporting System 2020).

**Compliance Guidelines**
- The provider must submit the annual immunization report within a time frame specified by the
Immunization Program (usually from October 1 through November 30 of each year).
• The Immunization Program tracks the immunization report status of each provider and sends this information to Child Care Licensing.

Risk Level
High

Corrective Action for 1st Instance
Citation and CMP Warning

(15) The provider shall ensure that each child's information is kept confidential and not released without written parental permission except to the department.

Rationale/Explanation
Child care programs routinely handle confidential information about enrolled children, families, and staff. Confidentiality must be maintained to protect the child and family and is defined by law. Serving children and families involves significant facility responsibilities in obtaining, maintaining, and sharing confidential information. Sharing of confidential information should be selective and should be based on a need-to-know and on the parent's/guardian's authorization for disclosure of such information. CFOC 4th ed. Standard 9.4.1.3 p.p. 409. Prior informed, written consent of the parent/guardian is required for the release of records/information (verbal and written) to other service providers, including the process for secondary release of records. Consent forms should be in the native language of the parents/guardians, whenever possible, and communicated to them in their normal mode of communication. CFOC 4th ed. Standard 9.4.2.1 p.p.418.

Compliance Guidelines
Confidential information includes personal identifiable information such as birthdates, addresses, and phone numbers, in addition to health information. To protect the confidentiality of child and family information, the provider should:
• Follow federal, state, and local laws, and train staff to follow these regulations.
• Only share information on a need-to-know basis with authorized individuals.
• Keep written information about the children in a safe place and out of the view of others.
• Refrain from discussing confidential information in the presence of others in the facility including children.

Corrective Action for 1st Instance
The corrective action will be based on the severity of harm that was caused or likely to be caused as a result of a rule violation.
This section provides an overview of the personnel and training requirements for those individuals involved with a child care facility.

**Rationale/Explanation**
Licensing rules require that individuals who work or associate with a child care program (including employees, volunteers, parents, household members, guests, etc.) have at least basic qualifications to do so. Individuals who are qualified and trained are more likely to have appropriate interactions with the children they associate with. Education is an ongoing, lifelong process and child care staff need continuous education about health and safety related subject matter. Staff members who are current on health related topics are better able to prevent, recognize, and correct health and safety problems. CFOC 4th ed. Guiding Principle 17. p. xx.

The National Association for the Education of Young Children's (NAEYC) recommends a multilevel training program that addresses both preservice and ongoing training for administrators and staff. CFOC 4th ed. Standard 1.3.2.1 p.p. 12.

**Preservice Training**
Any individual who is newly employed by the program is required to receive preservice training.

Preservice training consists of at least 2.5 hours of training and must be:
- Completed before (but not earlier than 6 months before) beginning job duties, or
- Completed no later than 10 working days after beginning job duties as long as the individual does not have unsupervised contact with any child in care before their preservice training is completed.

Additional topics that are crucial for providers and staff and count as CCL required training time include:
- Culturally and linguistically appropriate practices to meet the developmental needs of children
- Current research and best practices relating to the skills necessary to engage families
- Culturally and linguistically appropriate practices to engage families

**Annual Child Care Training**
Individuals who are required to have annual child care training include:
- All regular employees who care for children regardless of the number of hours worked each week. This includes employees who have dual roles such as a driver who cares for the children when not driving.

Additional topics that are crucial for providers and staff and count as CCL required training time include:
- Culturally and linguistically appropriate practices to meet the developmental needs of children
- Current research and best practices relating to the skills necessary to engage families
Employees and volunteers who never have caregiving duties (i.e., they are not responsible for meeting the needs of the children, including protection and supervision), such as cooks, secretaries, receptionists, bookkeepers, custodians, drivers, and maintenance workers, do not need to complete annual training. Annual child care training hours are calculated from the license start date through the license end date. To be in compliance:

- Caregivers must complete at least 10 hours of child care training each license year.
- The provider must ensure that each individual's required annual child care training is complete before the license expiration date. A child care license will not be renewed until training hours have been completed for all individuals as required by rule.

(1) The provider shall be present at the home at least 50% of the time each week the program is open for business.

Compliance Guidelines
- This rule does not prevent the provider from taking a vacation or leave as long as a qualified caregiver is present to meet the provider's responsibilities.
- Volunteers who provide caregiving duties will be required to complete preservice training.

Risk Level
Moderate
Corrective Action for 1st Instance
Citation Warning when:
The provider is not present 50% of the time each week that a child is in care.

(2) If the provider is not present, the provider shall ensure that there is at least one covered individual who is 18 years old or older present at the facility when there is a child in care.

Compliance Guidelines
- The provider or a caregiver who is at least 18 years old must be on the premises, in each vehicle, and at each offsite activity whenever there is a child in care.
- A 16- or 17-year-old caregiver may have unsupervised contact with children in care while they are at the facility as long as there is a caregiver who is at least 18 years old on the premises. They may not be alone with the children during transportation and offsite activities.

Risk Level
High
Corrective Action for 1st Instance
Citation and CMP Warning when:
The provider or a caregiver who is at least 18 years old is not present when a child is in care.
(3) The provider shall ensure that all employees and volunteers are supervised, qualified, and trained to:
   (a) meet the needs of the children as required by rule, and
   (b) be in compliance with licensing requirements under Rule R430-50.

Rationale/Explanation
In both large and small family child care homes, staff members must have the education and experience to meet the needs of the children in care. CFOC 4th ed. Standard 1.3.3.1 p.p. 20.

(4) The provider shall ensure that caregivers:
   (a) are at least 16 years old;
   (b) are deemed eligible by a CCL background check before becoming involved with child care;
   (c) receive at least 2-1/2 hours of preservice training before caring for children;
   (d) know and follow any applicable laws and requirements under Rule R430-50;
   (e) complete at least 10 hours of child care training each year, based on the facility's license date, or at least 45 minutes of child care training each month they work if hired partway through the facility's licensing year; and
   (f) do not have unsupervised contact with any child in care, including during offsite activities and transportation, if the caregivers are younger than 18 years old.

Rationale/Explanation
Many children attend child care programs every day. It is critical that they have the opportunity to grow and learn in a healthy and safe environment with caring and professional caregivers. The amount of education and child care experience impacts a caregiver's ability to respond appropriately to the needs of children. CFOC 4th ed. Standard 1.3.2.3 p.p. 14.

Compliance Guidelines
• Individuals who are younger than 16 years old are not approved to be caregivers.
  - It is a lack of supervision if a child is left in the care of an individual younger than 16 years old.
• Each caregiver must pass a background check according to the rules found in "Section 8: Background Checks."
• Records must verify that each caregiver completed preservice and annual child care training as required by rule.
  - Any regular employee who cares for children (regardless of the number of hours) is required to have annual child care training.
• If a staff member changes from a position that does not require annual training to a position that does, the total number of required training hours will be counted from the start date of their new position.
• When an individual is on approved leave of absence for more than one month, such as maternity leave, 45 minutes for every full month of absence can be deducted from the total required annual training hours. The table below may be used in calculating the required number of annual child care training hours for a new employee. (This is in addition to the required 2.5 hours of preservice training.) In the first column, find the month that the employee started work at the facility. Move
horizontally across that row to the month that the provider’s child care license expires. For example, if an employee began work in May and the provider’s license expires in October, the new employee would need 3 hours and 45 minutes of training before the end of October.

### Annual Training Time Required for Employees Hired Partway Through Licensing Year

<table>
<thead>
<tr>
<th>Month Person Started</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
<th>April</th>
<th>May</th>
<th>June</th>
<th>July</th>
<th>Aug</th>
<th>Sept</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jan</td>
<td>0</td>
<td>45min</td>
<td>1.5 hr</td>
<td>2.25 hr</td>
<td>3 hr</td>
<td>3.75 hr</td>
<td>4.5 hr</td>
<td>5.25 hr</td>
<td>6 hr</td>
<td>6.75 hr</td>
<td>7.5 hr</td>
<td>8.25 hr</td>
</tr>
<tr>
<td>Feb</td>
<td>8.25 hr</td>
<td>0</td>
<td>45min</td>
<td>1.5 hr</td>
<td>2.25 hr</td>
<td>3 hr</td>
<td>3.75 hr</td>
<td>4.5 hr</td>
<td>5.25 hr</td>
<td>6 hr</td>
<td>6.75 hr</td>
<td>7.5 hr</td>
</tr>
<tr>
<td>March</td>
<td>7.5 hr</td>
<td>8.25 hr</td>
<td>0</td>
<td>45min</td>
<td>1.5 hr</td>
<td>2.25 hr</td>
<td>3 hr</td>
<td>3.75 hr</td>
<td>4.5 hr</td>
<td>5.25 hr</td>
<td>6 hr</td>
<td>6.75 hr</td>
</tr>
<tr>
<td>April</td>
<td>6.75 hr</td>
<td>7.5 hr</td>
<td>8.25 hr</td>
<td>0</td>
<td>45min</td>
<td>1.5 hr</td>
<td>2.25 hr</td>
<td>3 hr</td>
<td>3.75 hr</td>
<td>4.5 hr</td>
<td>5.25 hr</td>
<td>6 hr</td>
</tr>
<tr>
<td>May</td>
<td>6 hr</td>
<td>6.75 hr</td>
<td>7.5 hr</td>
<td>8.25 hr</td>
<td>0</td>
<td>45min</td>
<td>1.5 hr</td>
<td>2.25 hr</td>
<td>3 hr</td>
<td>3.75 hr</td>
<td>4.5 hr</td>
<td>5.25 h</td>
</tr>
<tr>
<td>June</td>
<td>5.25 h</td>
<td>6 hr</td>
<td>6.75 hr</td>
<td>7.5 hr</td>
<td>8.25 hr</td>
<td>0</td>
<td>45min</td>
<td>1.5 hr</td>
<td>2.25 hr</td>
<td>3 hr</td>
<td>3.75 hr</td>
<td>4.5 hr</td>
</tr>
<tr>
<td>July</td>
<td>4.5 hr</td>
<td>5.25 hr</td>
<td>6 hr</td>
<td>6.75 hr</td>
<td>7.5 hr</td>
<td>8.25 hr</td>
<td>0</td>
<td>45min</td>
<td>1.5 hr</td>
<td>2.25 hr</td>
<td>3 hr</td>
<td>3.75 hr</td>
</tr>
<tr>
<td>Aug</td>
<td>3.75 hr</td>
<td>4.5 hr</td>
<td>5.25 h</td>
<td>6 hr</td>
<td>6.75 hr</td>
<td>7.5 hr</td>
<td>8.25 hr</td>
<td>0</td>
<td>45min</td>
<td>1.5 hr</td>
<td>2.25 hr</td>
<td>3 hr</td>
</tr>
<tr>
<td>Sept</td>
<td>3 hr</td>
<td>3.75 hr</td>
<td>4.5 hr</td>
<td>5.25 h</td>
<td>6 hr</td>
<td>6.75 hr</td>
<td>7.5 hr</td>
<td>8.25 h</td>
<td>0</td>
<td>45min</td>
<td>1.5 hr</td>
<td>2.25 hr</td>
</tr>
<tr>
<td>Oct</td>
<td>2.25 hr</td>
<td>3 hr</td>
<td>3.75 hr</td>
<td>4.5 hr</td>
<td>5.25 h</td>
<td>6 hr</td>
<td>6.75 hr</td>
<td>7.5 hr</td>
<td>8.25 hr</td>
<td>0</td>
<td>45min</td>
<td>1.5 hr</td>
</tr>
<tr>
<td>Nov</td>
<td>1.5 hr</td>
<td>2.25 hr</td>
<td>3 hr</td>
<td>3.75 hr</td>
<td>4.5 hr</td>
<td>5.25 h</td>
<td>6 hr</td>
<td>6.75 hr</td>
<td>7.5 hr</td>
<td>8.25 hr</td>
<td>0</td>
<td>45min</td>
</tr>
<tr>
<td>Dec</td>
<td>45min</td>
<td>1.5 hr</td>
<td>4.5 hr</td>
<td>3 hr</td>
<td>3.75 hr</td>
<td>4.5 hr</td>
<td>5.25 h</td>
<td>6 hr</td>
<td>6.75 hr</td>
<td>7.5 hr</td>
<td>8.25 hr</td>
<td>0</td>
</tr>
</tbody>
</table>

**Risk Level**

**Moderate**

**Corrective Action for 1st Instance**

Citation Warning when a caregiver:
- Did not receive 2-1/2 hours of preservice training.
- Had unsupervised contact with a child in care before completing preservice training.
- Did not complete the required annual child care training hours by the license expiration date.

**Risk Level**

**Low**

**Corrective Action for 1st Instance**

Warning when a caregiver:
Received preservice training, but it was earlier than 6 months before or later than 10 days after beginning job duties.

(5) The provider shall ensure that any other staff such as drivers, cooks, and clerks:
(a) are deemed eligible by a CCL background check before becoming involved with child care;
(b) receive at least 2-1/2 hours of preservice training before beginning job duties; and
(c) know and follow any applicable laws and requirements under Rule R430-50.

Rationale/Explanation
The purpose of this rule is to ensure that the interaction between all employees and children is appropriate and in accordance with licensing rules. CFOC 4th ed. Guiding Principle 4. p.p. xix.

Compliance Guidelines
• Each employee must pass a background check according to the rules found in “Section 8: Background Checks.”
• Personnel records must verify that each employee completed preservice training according to rule.
• Any employee who cares for children (regardless of their other job duties) must be at least 16 years old and receive annual child care training.
• If a covered individual takes on caregiving responsibilities and tasks, they become a caregiver.

Risk Level
Moderate
Corrective Action for 1st Instance
Citation Warning when an employee:
• Did not receive 2-1/2 hours of preservice training.
• Had unsupervised contact with a child in care before completing preservice training.

Risk Level
Low
Corrective Action for 1st Instance
Warning when an employee:
Received preservice training, but it was earlier than 6 months before or later than 10 days after beginning job duties.

(6) The provider shall ensure that volunteers are deemed eligible by a CCL background check before becoming involved with child care.

Compliance Guidelines
• Each individual who volunteers at the child care facility at any time a child is in care (except the parent of an enrolled child) is required to have a background check in accordance with rules in “Section 8: Background Checks.”
• If an individual volunteers only when there are no children in care, for example, they only volunteer after child care hours, they will not be required to have a background check.
• Licensing statute defines child care as care for children through age 12 years and for children with disabilities through age 18 years. Thirteen- to fifteen-year-olds are not considered children in

Section 7 - Personnel and Training Requirements
If they help care for younger children (and are not paid), they are considered volunteers and must meet the requirements of a volunteer.

**Risk Level**
High

**Corrective Action for 1st Instance**
Citation and CMP Warning

(7) The provider shall submit a background check as required in Section R430-50-8 for each guest who is 12 years old and older and stays in the home for more than two weeks.

**Compliance Guidelines**
A guest may not be alone in a room or area with any child in care. A caregiver or other employee who is at least 18 years old and has passed a CCL background check must be in the same room or area.

**Risk Level**
High

**Corrective Action for 1st Instance**
Citation and CMP Warning when:
A guest has unsupervised contact with a child in care.

(8) The provider shall ensure that household members who are:
   (a) 12 to 17 years old are deemed eligible by a CCL background check; and
   (b) 18 years old or older are deemed eligible by a CCL background check that includes fingerprints.

**Compliance Guidelines**
• Each household member who is 12 years old or older must pass a background check according to the rules found in “Section 8: Background Checks.”
• A household member who is younger than 18 years old may not be alone with any child in care in the facility, during transportation, or during offsite activities. A caregiver or other adult who is at least 18 years old and has passed a CCL background check must be on the premises.

**Risk Level**
High

**Corrective Action for 1st Instance**
Citation and CMP Warning

(9) The provider shall ensure that individuals who provide Individualized Educational Plan (IEP) or Individualized Family Service plan (IFSP) services such as physical, occupational, or speech therapists:

---

Section 7 - Personnel and Training Requirements
(a) provide proper identification before having access to the facility or to a child at the facility; and
(b) have received the child's parent's permission for services to take place at the facility.

Compliance Guidelines
• If the parent of a child with an IEP (Individualized Education Program) or an IFSP (Individualized Family Service Plan) has an agreement with a school or other agency for their child to receive services at the child care facility, the individual providing the services is not required to have a CCL background check.
• With proper authorization and identification, the child may be left alone with the individual providing IEP or IFSP services.
• While services are being offered, the child will be considered the responsibility of the school or other agency.

Risk Level
Moderate
Corrective Action for 1st Instance
Citation Warning

(10) The provider shall ensure that individuals from law enforcement, Child Protective Services, the department, and any similar entities provide proper identification before having access to the facility or to a child at the facility.

Compliance Guidelines
With proper identification, a child may be left alone with a law enforcement officer or a caseworker from Child Protective Services (CPS).

Risk Level
Moderate
Corrective Action for 1st Instance
Citation Warning

(11) The provider shall ensure that preservice training includes at least the following topics:
(a) job description and duties;
(b) current department rule Sections R430-50-7 through R430-50-24;
(c) disaster preparedness, response, and recovery;
(d) pediatric first aid and cardio pulmonary resuscitation (CPR);
(e) children with special needs;
(f) safe handling and disposal of hazardous materials;
(g) prevention, signs and symptoms of child abuse and neglect, including child sexual abuse, and legal reporting requirements;
(h) principles of child growth and development, including brain development;
(i) prevention of shaken baby syndrome and abusive head trauma, and coping with crying babies;
(j) prevention of sudden infant death syndrome (SIDS) and the use of safe sleeping practices;
(k) recognizing the signs of homelessness and available assistance;
(l) a review of the information in each child’s health assessment in the caregiver’s assigned group including allergies, food sensitivities, and other special needs; and
(m) an introduction and orientation to the children in care.

Rationale/Explanation
Orientation ensures that all staff members receive specific and basic training for the work they will be doing and are informed about their new responsibilities. Training ensures that staff members are challenged and stimulated, have access to current knowledge, and have access to education that will qualify them for new roles. CFOC 4th ed. Standard 1.4.2.1 p.p. 23.

Compliance Guidelines
• Preservice records must confirm that all individuals who are new to the child care program have received preservice training in all of the required areas.
• Training documentation may be kept as a hardcopy or electronically.
• Pediatric first aid and cardio pulmonary resuscitation (CPR) training does not have to include certification.
• The provider may use their own method of documenting each person’s preservice training as long as the requirements of this rule are met.
• An optional technical assistance form to document preservice training is available under “Forms and Documents.”

Risk Level
Low

Corrective Action for 1st Instance
Warning

(12) The provider shall ensure that annual child care training includes at least the following topics:
   (a) current department rule Sections R430-50-7 through R430-50-24;
   (b) disaster preparedness, response, and recovery
   (c) pediatric first aid and CPR;
   (d) children with special needs;
   (e) safe handling and disposal of hazardous materials;
   (f) the prevention, signs and symptoms of child abuse and neglect, including child sexual abuse, and legal reporting requirements;
   (g) principles of child growth and development, including brain development;
   (h) prevention of shaken baby syndrome and abusive head trauma, and coping with crying babies;
   (i) prevention of sudden infant death syndrome (SIDS) and use of safe sleeping practices; and
   (j) recognizing the signs of homelessness and available assistance.
Rationale/Explanation
Because of the nature of their caregiving/teaching tasks, caregivers/teachers must attain multifaceted knowledge and skills. Child health and employee health are integral to any education/training curriculum and program management plan. CFOC 4th ed. Standards 1.4.4.1 p.p. 28.

Compliance Guidelines
• Annual training must include a review of each licensing rule in sections 50-7 through 50-24 and not just the general category of the rule section.
• Training records must verify that each individual received training on the topics listed in this rule as well as licensing rules.
  - An optional technical assistance form to record each individual's annual training can be found under “Forms and Documents”.
• Complete training records must be available for review at the annual Announced Inspection or submitted to CCL by the license expiration date.
  - To submit the documentation, the provider may mail, fax, or email it to CCL, or upload it on the provider's Child Care Licensing portal.
• Pediatric first aid and cardiopulmonary resuscitation (CPR) training can include full certification, but does not have to include certification.
• Individuals who are hired within 60 calendar days before the license expires must complete the prorated number of training hours, but their review of all of the training topics is not required until the provider's next license year.

Risk Level
Low
Corrective Action for 1st Instance
Warning

(13) The provider shall ensure that at least half of the required annual training is interactive.

Compliance Guidelines
Examples of approved interactive training include:
• Training offered by CCL on licensing rules
• All classes offered by Care About Childcare
• Classes and workshops at child care, early childhood, and parenting conferences
• Real-time, interactive webinars dealing with child care
• Online instruction that requires completing a test for understanding
• Any high school or college class in child development or related subject (Hours of attendance count as clock time if the student attends in person as opposed to working online or independent study. One semester credit equals 15 clock hours and one quarter credit equals 10 clock hours.)
• Attendance at a CCL Committee meeting
• Training by a child care association, if the certificate has “child care related” in the topic
Examples of independent, or non interactive training include:
• Researching and planning curriculum (but not the time spent preparing materials such as making copies and presenting curriculum to the children)
• Watching recordings of webinars on topics relating to child care
• Reading books and watching videos related to child care
• Doing homework for a high school or college child development class
• Using training packets or watching recordings offered by Care About Child Care
• Listening to the audio recording of the Residential Advisory Committee Meeting

Anyone may deliver interactive training including child care providers and staff. When this is the case:
• The individual delivering the training can count it as independent or non interactive training.
• The individual being trained can count it as interactive instruction.

The following topics and classes do not count toward annual child care training:
• Self-help classes such as anger or stress management
• Time spent doing yoga or meditating
• Technical assistance from CCL staff
• ESL and other language classes
• Craft classes, such as origami, scrapbooking, sewing, etc.
• Attendance at a child’s classes or lessons, such as music or dance lessons
• Watching reality TV and talk shows
• Preparing (making copies, cutting, etc.) and presenting curriculum to children
• Volunteering in a classroom
• Obtaining and submitting fingerprints to CCL
• DWS policy-related webinars

Additional guidelines:
• Annual training for all individuals as required in rule must be completed by the end of the licensing year.
• For training to be considered complete, each person must have received training on the required rules and topics, and for the required number of hours.
• If training is not complete for all required individuals at the time of the annual Announced Inspection, the provider may (before their license expires):
   - Upload the documentation to the provider’s Child Care Licensing portal, or
   - Mail, fax, or e-mail the documentation to CCL.

**Risk Level**
Low

**Corrective Action for 1st Instance**
Warning
(14) The provider shall ensure that at least one covered individual with a current Red Cross, American Heart Association, or equivalent pediatric first aid and CPR certification is present when children are in care:
   (a) at the facility;
   (b) in each vehicle transporting children; and
   (c) at each offsite activity.

Rationale/Explanation
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. CFOC 4th ed. Standards 1.4.3.1 p.p. 26.

Compliance Guidelines
The person with a current first-aid certification and the person with a current CPR certification do not have to be the same person.

- CPR training must be Red Cross or American Heart Association certified or be equivalent. A first-aid certification from any source is acceptable.
  - Current certification for RNs, LPNs, or First Responders will be accepted for both CPR and first aid. Due to differences in training courses, a CNA certificate is not an approved CPR certification.

- CPR certification must include pediatric CPR training.
  - Training that includes basic life support (BLS) meets this requirement. (The card or certificate may not have the words “pediatric” or “infant and child” written on them.)
  - Although child CPR training is required, training on infant CPR is optional if the provider does not enroll infants or toddlers.

- The CPR and first aid certification must be current.
  - The expiration date on the first-aid and CPR card determines whether the certification is current.
  - When there is no expiration date on the card, and the issue date is less than a year old, the certification is considered current.
  - When the expiration date on the card has been added or altered, the trainer will need to verify that the certification is current.

Risk Level
Moderate

Corrective Action for 1st Instance
Citation Warning

(15) The provider shall ensure that CPR certification includes hands-on testing.
**Rationale/Explanation**
Pediatric CPR skills should be taught by demonstration and practice to ensure the technique can be performed in an emergency. CFOC 4th ed. Standard 1.4.3.1 p.p. 24

**Compliance Guidelines**
Online CPR training does not meet the requirement of this rule, unless there is a hands-on training component in addition to the online part of the training.

**Risk Level**
Moderate

**Corrective Action for 1st Instance**
Citation Warning

(16) The provider shall ensure that current pediatric first aid and CPR certification records for each covered individual required by this rule to have them are kept on-site for review by the department.

**Rationale/Explanation**

**Risk Level**
Low

**Corrective Action for 1st Instance**
Warning
The rules in this section explain the provider’s and other covered individuals’ responsibilities regarding background checks. The rules regulate how to obtain a background check, when it is required, and what criteria are used in determining if an individual is found to be eligible or not eligible after a background check.

**Rationale/Explanation**
To ensure their safety and physical and mental health, children should be protected from any risk of abuse or neglect. Performing diligent background screenings also protects the child care facility against future legal challenges. CFOC 4th ed. Standard 1.2.0.2 p.p. 10.

**Covered Individuals**
Covered individuals are those who are involved with a child care program and are required to have a background check as explained below. An individual who is found not eligible by a background check must not be involved with a child care program and will be required to leave if found at a facility during child care hours. In order to ensure compliance with the rules, and verify identity, licensors may ask for a government issued photo ID for covered individuals at the facility.

- **Provider / Owner**
  - The provider is required to have a background check.

- **Household Members**
  - All individuals age 12 years and older who reside in the home are required to have a background check.
  - Review “Section 7: Personnel and Training Requirements” for the rules and information about background check requirements for household members.

- **Caregivers and Other Employees**
  - Individuals who care for the children are required to be found eligible by taking a background check.
  - Any individual who is hired to work for the child care program is an employee who must have a current background check.

- **Volunteers, Guests, and Others Who May Have Access to Children**
  - Volunteers need a background check.
  - A guest who stays continuously in the home for more than 2 weeks must have a background check.
  - An individual who rents space in the provider’s home will be required to have a background check unless exempt under certain conditions. Refer to “Section 9: Facility” for more information.
  - Any individual 12 years or older who resides or moves into a child care facility is considered a covered individual and is required to have a background check. This applies whether or not the individual directly participates in the child care program.
**CCL Background Check Process**

All prospective covered individuals must be found eligible by a CCL background check before becoming involved with a child care program. Background checks from other organizations do not meet the requirements of this rule. For Child Care Licensing, a background check includes examining a covered individual's background through the following eight sources which encompass three in-state checks, two national checks, and three interstate checks. CCL also checks the Utah sex offender registry for the names of any registered sex offenders who reside in the vicinity of the child care facility.

<table>
<thead>
<tr>
<th>Utah</th>
<th>National</th>
<th>Interstate</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Criminal registry or repository</td>
<td>4. FBI Next Generation Identification</td>
<td>6. Criminal registry or repository</td>
</tr>
<tr>
<td>• Uses fingerprints</td>
<td>• Uses fingerprints</td>
<td>• In any other state where the individual has resided in the past 5 years</td>
</tr>
<tr>
<td>• Includes juvenile records</td>
<td>• Retains fingerprints for a real-time criminal report from FBI (Rap Back service)</td>
<td>• For individuals 18 years old and older</td>
</tr>
<tr>
<td>• Fingerprints not required for minors, except 16- or 17-year-old caregivers working for a DWS-approved facility</td>
<td>• For individuals 18 years old and older</td>
<td></td>
</tr>
<tr>
<td>2. Sex offender registry or repository</td>
<td>5. National Crime Information Center (NCIC) National Sex Offender Registry (NSOR)</td>
<td>7. Sex offender registry or repository</td>
</tr>
<tr>
<td>• For individuals 12 years old and older</td>
<td>• For individuals 18 years old and older</td>
<td>• In any other state where the individual has resided in the past 5 years</td>
</tr>
<tr>
<td>• Checks all facility addresses for names of registered sex offenders living in vicinity of child care facility</td>
<td>• For individuals 18 years old and older</td>
<td>• For individuals 18 years old and older</td>
</tr>
<tr>
<td>• For individuals 12 years old and older</td>
<td></td>
<td>• In any other state where the individual has resided in the past 5 years</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• For individuals 18 years old and older</td>
</tr>
</tbody>
</table>

CCL participates in the FBI Next Generation Identification (NGI) system. The NGI process uses fingerprint identification to identify individuals arrested and prosecuted for crimes. With this system, authorized government agencies will receive an individual's criminal history record reported to the FBI and State.

It usually takes 3 full days for OBPS (Office of Background Processing and Security) to complete a background check after the request (including fingerprints if required) has been submitted, authorized, and paid for. However, the background check may take longer when the individual has resided outside of Utah within the past five years.
The diagram below summarizes the steps that the covered individual, the provider, and CCL must complete in the background check process. A detailed explanation of the process is described in the Compliance Guidelines sections below.

When authorizing an individual's background check or when associating an individual with their facility, the facility staff authorized for completing this process will be required to acknowledge the following statement:

Based upon my information and belief, this individual:

(a) has not been convicted of, has not pleaded no contest to, or is not currently subject to a plea in abeyance or diversion agreement for a felony or misdemeanor;
(b) has not been adjudicated in juvenile court of committing an act that if committed by an adult would be a felony or misdemeanor;
(c) has never had a supported finding or is being investigated by the Department of Human Services of abuse or neglect of a child; or
(d) is not list on the Utah or national sex offender registry.

(1) Before a new covered individual becomes involved with child care in the program, the provider shall use the CCL provider portal search to:
   (a) verify that the individual is eligible; and
   (b) associate that individual with their facility if the covered individual appears in the search.

Rationale/Explanation
This screening requirement may protect children from abuse and reduce liability risks while reassuring parents/guardians that their children are safe from violent and sexual offenders and those with related criminal histories. CFOC 4th ed. Standard 10.3.3.2 p.p. 434.

Compliance Guidelines
• If the individual's background check is active and they have been found eligible by the FBI fingerprint check:
   - They are not required to submit a new background check and associated fee.
   - The provider is required to associate the individual with their child care facility.
   - The covered individual may then become involved with the child care facility.

• If the individual's background check is active, but they have not been found eligible by the FBI fingerprint check as required by rule, they must submit a new CCL background check request form, fingerprints, and all associated fees.

• If the individual's name does not show up in the search (indicating that they do not have an active CCL background check), they must submit a CCL background check request form, fingerprints (if required), and all associated fees.

• Individuals who have not been associated with any CCL facility in Utah for the past 180 days (6 months) will not show up in the search and will be required to resubmit a background check request, including fingerprints and fees, in order to be associated with child care again.

Risk Level
Moderate
Corrective Action for 1st Instance
Citation Warning

(2) Before a new covered individual who does not appear in the CCL provider portal search becomes involved with child care in the program, the provider shall:
   (a) have the individual submit an online background check form and fingerprints for individuals age 18 years old and older;
   (b) authorize the individual's background check through the CCL provider's portal,
   (c) pay any required fees; and
   (d) receive written notice from CCL that the individual is eligible.
This rule applies to covered individuals who have never had a CCL background check, and individuals who have not been found eligible by a CCL background check, but are new to a child care facility.

This rule does not apply to children who reside in the facility and are turning 12 years old. For information about their background check requirements, refer to 90-8(4).

For a new covered individual who has never had a CCL background check

- The covered individual must submit a background check request form and fingerprints if required.
  - Instructions for requesting a CCL background check and the background check form are found under “Background Checks.”
  - Instructions for submitting fingerprints, if required, are found at: https://childcarelicensing.utah.gov/BgsHowTo.html.

- The provider must authorize the form through their CCL portal and ensure that all fees are paid.
  - For instructions on paying fees, go to the “Payments” page on the CCL website.

- CCL will begin checking the individual’s background when:
  - The individual has submitted a complete background request form,
  - The provider has authorized the background check to be run,
  - Required fingerprints have been submitted, and
  - All fees have been paid.

- CCL will cancel the background check request if required fingerprints are not submitted and/or fees are not paid within 10 working days of the provider’s authorization.

- If the covered individual is found eligible by the background check:
  - CCL will notify the provider and the individual of the background check results.
  - An electronic background check card (with a Covered Individual Number) will be emailed to the individual and to the provider.
  - CCL will associate the individual with the child care facility.
  - “Eligible,” or “Temporary Eligible” will be displayed as the status on the CCL provider portal.
  - The individual may then be involved with the facility.

- As soon as a prospective employee has been found eligible by either the FBI or Utah criminal registry fingerprint check, CCL will allow the individual to become involved with the child care facility on a provisional basis.
  - This is allowed on condition that the individual never has unsupervised contact with any child. The individual must be supervised at all times by an adult who has been found eligible by the CCL background check.
- The background status on the provider's CCL portal will display as “Temporary Eligible.”
- The individual's involvement with the child care program is considered provisional until they pass the entire CCL background check from all sources.

- If the covered individual is found not eligible by the background check:
  - They may not be involved with, or living in a child care facility.
  - “Denied” will be displayed as the status; and both the provider and the covered individual will be notified in writing.
  - Previously denied individuals who may now be found eligible by the background check will be required to resubmit a background check request, including fingerprints and fees, in order to be associated with child care.

**Risk Level**

High

**Corrective Action for 1st Instance**

Citation and CMP Warning when:

- A new covered individual was involved with the child care program without being found eligible by a CCL background check.

**Risk Level**

Moderate

**Corrective Action for 1st Instance**

Citation Warning when:

- A temporarily cleared individual (one who has been found eligible by only part of the CCL background check) had unsupervised contact with the children.

(3) To keep their background check eligibility current, the provider shall also ensure that a new background check form and fingerprints are submitted and authorized and fees are paid for any covered individual who has:

- resided outside of Utah since their last background check was completed;
- not been associated with an active, CCL approved child care facility within the past 180 days; or
- has turned 18 years old and has not previously submitted fingerprints for a CCL background check. If the 18-year-old has previously submitted fingerprints for a CCL background check, only a new background check form will be required.

(4) Within ten working days from when a child who resides in the facility turns 12 years old, the provider shall:

- ensure that an online background check form is submitted;
- authorize the child's background check through the CCL provider's portal; and
- pay any required fees.

- This rule applies to covered individuals who have never had a CCL background check,
and individuals who have not been found eligible by a CCL background check, but are new to a child care facility.
• This rule does not apply to children who reside in the facility and are turning 12 years old. For information about their background check requirements, refer to 90-8(4).

For a new covered individual who has never had a CCL background check

• The covered individual must submit a background check request form and fingerprints if required.
  -Instructions for requesting a CCL background check and the background check form are found under “Background Checks.”
  -Instructions for submitting fingerprints, if required, are found at: https://childcarelicensing.utah.gov/BgsHowTo.html.

• The provider must authorize the form through their CCL portal and ensure that all fees are paid.
  -For instructions on paying fees, go to the “Payments” page on the CCL website

• CCL will begin checking the individual’s background when:
  -The individual has submitted a complete background request form,
  -The provider has authorized the background check to be run,
  -Required fingerprints have been submitted, and
  -All fees have been paid.

• CCL will cancel the background check request if required fingerprints are not submitted and/or fees are not paid within 10 working days of the provider’s authorization.

• If the covered individual is found eligible by the background check:
  -CCL will notify the provider and the individual of the background check results.
  -An electronic background check card (with a Covered Individual Number) will be emailed to the individual and to the provider.
  -CCL will associate the individual with the child care facility.
  -“Eligible,” or “Temporary Eligible” will be displayed as the status on the CCL provider portal.
  -The individual may then be involved with the facility.

• As soon as a prospective employee has been found eligible by either the FBI or Utah criminal registry fingerprint check, CCL will allow the individual to become involved with the child care facility on a provisional basis.
  -This is allowed on condition that the individual never has unsupervised contact with any child. The individual must be supervised at all times by an adult who has been found eligible by the CCL background check.
  -The background status on the provider’s CCL portal will display as “Temporary Eligible.”
  -The individual’s involvement with the child care program is considered provisional
until they pass the entire CCL background check from all sources.

- If the covered individual is found not eligible by the background check:
  - They may not be involved with, or living in a child care facility.
  - “Denied” will be displayed as the status; and both the provider and the covered individual will be notified in writing.
  - Previously denied individuals who may now be found eligible by the background check will be required to resubmit a background check request, including fingerprints and fees, in order to be associated with child care.

**Risk Level**
High

**Corrective Action for 1st Instance**
Citation and CMP Warning when:
- A new covered individual was involved with the child care program without being found eligible by a CCL background check.

**Risk Level**
Moderate

**Corrective Action for 1st Instance**
Citation Warning when:
- A temporarily cleared individual (one who has been found eligible by only part of the CCL background check) had unsupervised contact with the children.

(5) The provider shall ensure that fingerprints are prepared by a local law enforcement agency or an agency approved by local law enforcement.

**Compliance Guidelines**
- Care About Childcare is an approved agency where fingerprints may be prepared.
- Live Scan Fingerprint Locations are available in this document.

(6) If fingerprints are submitted electronically through live scan, the provider shall ensure that the agency taking the fingerprints is one that follows the department's guidelines.

(7) The department may consider a covered individual not eligible for any of the following reasons:
  - (a) LIS supported findings;
  - (b) the covered individual's name appears on the Utah or national sex offender registry;
  - (c) the covered individual refuses to consent to the criminal background check;
  - (d) the covered individual knowingly makes a false statement in connection with their background check;
  - (e) any felony convictions; or
  - (f) for any of the reasons listed under Subsection R430-50-8(8).
Rationale/Explanation
To ensure their safety and physical and mental health, children should be protected from any risk of abuse or neglect. CFOC 4th ed. Standard 1.2.0.2 p.p. 9.

Compliance Guidelines
If CCL denies a covered individual from being involved with child care, that individual may not have access to the child care facility or the children in care.

(8) The department may also consider a covered individual not eligible for any of the following convictions regardless of severity:
   (a) child pornography;
   (b) sexual enticing of a minor;
   (c) voyeurism;
   (d) a sexual exploitation act;
   (e) pornographic material or performance;
   (f) any crime against an individual;
   (g) providing dangerous weapons or firearms to a minor; or
   (h) driving under the influence (DUI) while a child is present in the vehicle.

(9) The department shall consider a covered individual eligible if the only background finding is a conviction or plea of no contest to a nonviolent drug offense that occurred ten or more years before the CCL background check was conducted.

(10) If the provider is deemed not eligible by CCL, the department may suspend or deny their license until the reason for the background check finding is resolved.

Compliance Guidelines
To suspend a license means that the license is temporarily revoked.

(11) If a covered individual is deemed not eligible by CCL, including that the individual has been convicted, has pleaded no contest, or is currently subject to a plea in abeyance or diversion agreement for a felony or misdemeanor, the provider shall prohibit that individual from being employed by the child care program or residing at the facility until the reason for the background check finding is resolved.

Compliance Guidelines
It is a rule violation if a covered individual who is found not eligible by the background check is involved with a child care facility, and consequently, the individual must leave the facility.

Risk Level
High

Corrective Action for 1st Instance
Citation and CMP Warning
If a covered individual is denied a license or employment based upon the criminal background check and disagrees with the information provided by the Department of Public Safety, the covered individual may appeal the information to the Department of Public Safety.

If a covered individual disagrees with a supported finding on the Department of Human Services LIS, the covered individual may appeal the finding to the Department of Human Services.

The provider and the covered individual shall notify the department within 48 hours of becoming aware of the covered individual's arrest warrant, felony or misdemeanor arrest, charge, conviction, or supported LIS finding. Failure to notify the department within 48 hours may result in disciplinary action, including revocation of the license.

**Compliance Guidelines**
- It is important that both the covered individual and the provider each report to CCL within 48 hours of having knowledge of any of the situations described above.
- An arrest does not automatically disqualify a covered individual from being involved with child care. CCL will use this information to verify if the nature of the arrest or charges will result in a denial.
- If an individual receives a ticket for a driving offense or other infraction of the law, it is not required to report the ticket to CCL unless it becomes an arrest warrant, felony or misdemeanor arrest, charge, conviction, or supported LIS finding.

**Risk Level**
Moderate

**Corrective Action for 1st Instance**
Citation Warning

The Executive Director of the department may overturn a CCL background check decision if the Executive Director determines that the nature of the background finding or mitigating circumstances do not pose a risk to children.

**Compliance Guidelines**
Any request to the Executive Director for a decision on a background check denial must be made through the CCL program appeal process. Please refer to “Section 5: Rule Violations and Penalties” for information about the appeal process.
This section provides rules and information that apply to the space requirements, structure, layout, and maintenance of the child care facility, both inside and outside.

Studies have shown that the quality of the physical designed environment of early child care centers is related to children's cognitive, social, and emotional development (e.g., size, density, privacy, well-defined activity settings, modified open-plan space, a variety of technical design features and the quality of outdoor play spaces). CFOC 4th ed. Standard 5.1.2.1 p.p. 216.

Equipment, materials, furnishings, and play areas should be sturdy, safe, and in good repair and should meet the recommendations of the U.S. Consumer Product Safety Commission (CPSC) for control of the following safety hazards. CFOC 4th ed. Standard 5.3.1.1 p.p. 253-254.

(1) The provider shall ensure that there is at least 35 square feet of indoor space for each child in care, including the provider's and employees' children.

**Rationale/Explanation**
Child behavior tends to be more constructive when sufficient space is organized to promote developmentally appropriate skills. Crowding has been shown to be associated with increased risk of developing upper respiratory infections. Also, having sufficient space will reduce the risk of injury from simultaneous activities. CFOC 4th ed. Standard 5.1.2.1 p.p. 215-216.

**Compliance Guidelines**
• Square footage is used as a factor in determining the maximum capacity of the facility.
• After the facility is measured at the Pre-License Inspection, generally rooms are not remeasured at subsequent inspections except when:
  - A room or area in the facility has been remodeled.
  - A provider requests a change to their capacity.
  - A room or area appears overcrowded with children or with items unrelated to child care.
• The provider may temporarily have children in an area with less than 35 square feet of space per child while in a group activity that requires less movement, such as eating, napping, listening to a story, watching a puppet show, working on an art project, or doing homework.

**Risk Level**
Moderate

**Corrective Action for 1st Instance**
Citation Warning
(2) The department may include floor space used for furniture, fixtures, or equipment as indoor space per child if the furniture, fixture, or equipment is used:
   (a) by children;
   (b) for the care of children; or
   (c) to store materials for children.

(3) The department may not include the following areas when measuring indoor space for children’s use:
   (a) bathrooms;
   (b) closets;
   (c) hallways;
   (d) lobbies; and
   (e) entryways.

(4) The department may limit the maximum allowed capacity for a child care facility based on local ordinances.

Rationale/Explanation
Some city ordinances limit the capacity of child care facilities. CCL will not issue a license with a greater capacity than allowed by the city where the facility is located. When a maximum capacity is stated on a city’s business license, or on a fire or kitchen inspection report, it may result in a reduced capacity when the child care license is issued or renewed.

(5) The provider shall ensure that the number of children in care at any given time does not exceed the capacity identified on the residential certificate.

Compliance Guidelines
• The state legislature has granted providers an allowance to care for additional, unrelated school-age children beyond their approved, licensed capacity.
  - Residential Certificate providers may care for up to two additional school-age children.
  - No change in capacity or variance is needed to obtain this allowance.
  - The additional, unrelated, two school-age children do not count in ratio or group size.
  - The additional, unrelated, two school-age children still require supervision and must be cared for in spaces that are free of hazards.
  - All rules and regulations other than ratio, group size, and capacity apply to the additional, school-age children.
  - School-age refers to a child age 5 years to 12 years old.
  - The children do not need to be enrolled in school in order to qualify to be one of the two additional, bonus children.
• “Children in care” refers to the children who are present at the facility, being transported, and at any offsite activity.
• A physical head count of the children who are present combined with the provider’s enrollment and attendance policies, and the sign-in and sign-out system may help ensure compliance with this rule.
• The provider may be over capacity for short periods of time during special events, such as parties where all enrolled children are invited, as long as supervision and ratios are maintained.

The two school age children do not count in the ratio or group size

Risk Level
Moderate
Corrective Action for 1st Instance
Citation Warning

(6) The provider shall ensure that any building or play structure on the premises constructed before 1978 that has peeling, flaking, chalking, or failing paint is tested for lead. If lead-based paint is found, the provider shall contact their local health department within five working days and follow required procedures for remediation of the lead hazard.

Rationale/Explanation
Ingestion of lead paint can result in high levels of lead in the blood, which affects the central nervous system and can cause mental retardation. Paint and other surface coating materials should comply with lead content provisions of the Code of Federal Regulations, Title 16, Part 1303. Lead is a neurotoxin. Even at low levels of exposure, lead can cause reduction in a child’s IQ and attention span, and result in reading and learning disabilities, hyperactivity, and behavioral difficulties. Lead poisoning has no “cure.” These effects cannot be reversed once the damage is done, affecting a child’s ability to learn, succeed in school, and function later in life. Other symptoms of low levels of lead in a child’s body are subtle behavioral changes, irritability, low appetite, weight loss, sleep disturbances, and shortened attention span. CFOC 4th ed. Standard 5.2.9.13 p.p. 251.

Lead-based paint and lead-contaminated dust are the most hazardous sources of lead poisoning in children and may be found in:
• House paints and paint used on outdoor play equipment made before 1978
• Imported vinyl mini-blinds made before 1997
• Imported toys
Compliance Guidelines
• Providers must regularly inspect inside and outside walls and play surfaces that are accessible to children for damaged (peeling, flaking, or chalking) paint.
• Any area with damaged paint should be tested for lead. If there are four areas with damaged paint, then there must be four tests for lead.
• If lead-based paint is found and the building or structure was built before 1978, the local health department or the Utah Department of Environmental Quality (DEQ) should be contacted for how to remove or repair the lead-based paint.
• According to DEQ regulations, if there is an area with 6 square feet or more of damaged paint indoors or an area with 20 square feet or more of damaged paint outdoors, then correction must be done by a certified individual.
• There must be documentation that paint was tested and it contains no lead, or that paint containing lead was repaired according to DEQ or local health department instructions.
• More information is available from the United States Environmental Protection Agency.

Risk Level
High
Corrective Action for 1st Instance
Citation and CMP Warning when:
• A building or play structure constructed before 1978 has untested failing paint in an area accessible to children.
• Any area has tested paint that contains lead and it has not been appropriately remediated.

Risk Level
Moderate
Corrective Action for 1st Instance
Citation Warning when:
A building or play structure constructed before 1978 has untested failing paint in an area inaccessible to children.

(7) The provider shall ensure that each room and indoor area that is used by children is ventilated by mechanical ventilation, or by windows that open and have screens.

Rationale/Explanation
As much fresh outdoor air as possible should be provided in rooms occupied by children. Screened windows should be opened whenever weather and the outdoor air quality permits or when children are out of the room. Indoor air should be kept as free from unnecessary chemicals as possible, including those emitted from air fresheners and other fragrances, cleaning products containing chemicals, aerosol sprays, and some furnishings.

The health and well-being of both the staff and the children can be greatly affected by indoor air quality. The air people breathe inside a building is contaminated with microbes shared among occupants, chemicals emitted from common consumer products and furnishings, and migration of...
polluted outdoor air into the facility. Air quality significantly impacts people's health. The health impacts from exposure to air pollution (indoor and outdoor) can include: decreased lung function, asthma, bronchitis, emphysema, learning and behavioral disabilities, and even some types of cancer. CFOC 4th ed. Standard 5.2.1.1 p.p. 224.

**Compliance Guidelines**
Areas used by children must be free of signs of inadequate ventilation such as mold growing in corners, a damp or musty smell, or a room with a temperature that varies greatly from the temperature of other rooms in the building.

**Risk Level**
Moderate

**Corrective Action for 1st Instance**
Citation Warning when:
• A room or area used by the children does not have either mechanical ventilation or a window to open.
• There are signs of inadequate ventilation in a room used by children.
• The ventilation is provided by an open, unscreened window that is accessible to children, and the room or area is above the facility's ground-floor level.

**Risk Level**
Low

**Corrective Action for 1st Instance**
Warning when:
The ventilation is provided by an open, unscreened window that is accessible to children, and the room or area is on the facility's ground floor or basement level.

(8) The provider shall ensure that rooms and areas have adequate light intensity for the safety of the children and the type of activity being conducted.

**Rationale/Explanation**
These levels of illumination facilitate cleaning, reading, comfort, completion of projects, and safety. Too little light, too much glare and confusing shadows are commonly experienced lighting problems. Inadequate artificial lighting has been linked to eyestrain, headache, and non-specific symptoms of illness. Lighting levels should be reduced during nap times to promote resting or napping behavior in children. During napping and rest periods, some degree of illumination must be allowed to ensure that staff can continue to observe children. CFOC 4th ed. Standard 5.2.2.1 p.p. 230-231.

**Compliance Guidelines**
It is a rule violation if an area being used by children is so dark that it is unsafe to go in or out.

**Risk Level**
Moderate
Corrective Action for 1st Instance
Citation Warning when:
There is inadequate lighting in a diapering or food preparation area, or if it is completely dark in a sleeping room.

Risk Level
Low
Corrective Action for 1st Instance
Warning when:
There is inadequate lighting in any other area used by the children.

(9) The provider shall maintain the indoor temperature between 65 and 82 degrees Fahrenheit.

Rationale/Explanation
A draft-free temperature of 68°F to 75°F should be maintained at thirty to fifty percent relative humidity during the winter months. A draft-free temperature of 74°F to 82°F should be maintained at thirty to fifty percent relative humidity during the summer months. CFOC 4th ed. Standard 5.2.1.2 p.p. 225.

According to the National Institutes of Health, there may be an association between sleeping room temperatures and increased risk of SIDS. It is recommended that sleeping rooms be kept at a temperature comfortable for a lightly-clothed adult, and infants should not be overly bundled or should not feel hot to the touch when sleeping. American Academy of Pediatrics. (2016 October).

Compliance Guidelines
• A thermometer may be used to check the air temperature in each infant and toddler room or area.
• The air temperature may be measured at the height at which the infants and toddlers sleep.
• The air temperature may be measured when an area seems to be too hot or too cold.
• In rooms used only for preschool and school-age children, the air temperature may be measured at table height when a room seems to be too hot or cold.

Risk Level
Moderate
Corrective Action for 1st Instance
Citation Warning when:
The temperature is out of range in a room used for infants or toddlers.

Risk Level
Low
Corrective Action for 1st Instance
Warning when:
The temperature is out of range in any room other than one used for infants/toddlers.
(10) The provider shall ensure that there is a working telephone at the facility, in each vehicle while transporting children, and during offsite activities.

Rationale/Explanation
The facility should provide at all times at least one working non-pay telephone or wireless communication device for general and emergency use. CFOC 4th ed. Standard 5.3.1.12 p.p. 259.

Compliance Guidelines
• A cell phone meets the requirements of this rule as long as there is a phone in the facility, each vehicle, and at offsite activities whenever children are present.
• A long range two-way communication device also meets the requirements of this rule.

Risk Level
Moderate
Corrective Action for 1st Instance
Citation Warning

(11) The provider shall ensure that there is at least one working toilet and at least one working handwashing sink accessible to each nondiapered child in care.

Rationale/Explanation
Toilets and hand sinks should be easily accessible to children and facilitate adult supervision. CFOC 4th ed. Standard 5.4.1.6. p.p. 262.

Compliance Guidelines
During regular operation hours, the required toilet and sink must be in working condition.
• It is a violation of rule 90-9(21) if there is only one toilet at the facility and it is not in working condition. In this case, the repair must be made immediately (within one hour) in order to provide child care services.
• The following are not acceptable toilets or sinks:
  - Indoor and outdoor portable toilets, such as chemical toilets, composting toilets, and bucket toilets
  - A portable sink with no water in it

(12) The provider shall ensure that there is at least one bathroom that provides privacy available for use by school-age children.

Rationale/Explanation
Children should be allowed the opportunity to practice modesty when independent toileting behavior is well-established in the majority of the group. CFOC 4th ed. Standard 5.4.1.2 p.p. 261.

Compliance Guidelines
A bathroom that provides privacy has a door or curtain that closes, and only one child at a time
uses the bathroom.

**Risk Level**
Moderate
**Corrective Action for 1st Instance**
Citation Warning

(13) If there is a swimming pool on the premises that is not emptied after each use, the provider shall:
(a) meet applicable state and local laws and ordinances related to the operation of a swimming pool;
(b) maintain the pool in a safe manner; and
(c) when not in use, cover the pool with a commercially-made safety enclosure that is installed according to the manufacturer’s instructions, or enclose the pool within at least a four-foot-high fence or solid barrier that is kept locked and that separates the pool from any other areas on the premises.

**Rationale/Explanation**
Where applicable, swimming pools and built-in wading pool equipment and materials should meet the health effects and performance standards of the National Sanitation Foundation or equivalent standards as determined by the local regulatory health authority. Proper pool operation and maintenance minimizes injuries. CFOC 4th ed. Standard 6.3.3.3 p.p. 300-301.

**Compliance Guidelines**
- All locks or latches on the fence or safety cover must be properly locked.
  - A pool fence must be locked with a key or combination lock.
  - For a pool cover, every latch must be engaged and all sides must be secured.
- When the pool is covered with a safety cover, commercially made product documentation must be available for review by CCL.
- If the law or rule from one agency is more strict than another, the provider must follow the most strict regulation.

**Risk Level**
High
**Corrective Action for 1st Instance**
Citation and CMP Warning

(14) If there is a hot tub with water in it on the premises, the provider shall make the hot tub inaccessible to children by:
(a) keeping the hot tub locked with a properly working cover; or
(b) enclosing the hot tub within at least a four-foot-high fence or solid barrier that is kept locked and that separates the hot tub from any other areas on the premises.

**Rationale / Explanation**
Children should not be permitted in hot tubs, spas, or saunas in child care. Areas should be secured to prevent any access by children. CFOC 4th ed. Standard 6.3.5.1. p.p. 302.

**Compliance Guidelines**

- This rule only applies to tubs with water in them. However, it should be noted that empty tubs with unsafe or unlocked covers can also be dangerous since children can get trapped in them.
- All locks or latches on the fence or safety cover must be properly locked.

**Risk Level**

High

**Corrective Action for 1st Instance**

Citation and CMP Warning

(15) The provider shall maintain buildings and outdoor areas in good repair and safe condition including:

(a) ceilings, walls, and floor coverings;
(b) lighting, bathroom, and other fixtures;
(c) draperies, blinds, and other window coverings;
(d) indoor and outdoor play equipment;
(e) furniture, toys, and materials accessible to the children; and
(f) entrances, exits, steps, and walkways including keeping them free of ice, snow, and other hazards.

**Rationale/Explanation**

Messy play and activities that lead to soiling of floors and walls is developmentally appropriate in all age groups, but especially among very young children, the same group that is most susceptible to infectious disease. These factors lead to soiling and contamination of floors and walls. A smooth, nonporous surface prevents deterioration and mold and is easier to clean and sanitize; therefore, helps prevent the spread of infectious diseases. To avoid transmission of disease within the group, and to maintain an environment that supports learning cleanliness as a value, all surfaces should be kept clean. CFOC 4th ed. Standard 5.3.1.6 p.p. 256-257.

Proper maintenance is a key factor when trying to ensure a safe play environment for children. Each playground is unique and requires a routine maintenance check program developed specifically for that setting. CFOC 4th ed. Standard 5.7.0.2 p.p. 277.

All walking surfaces, such as walkways, ramps, and decks, should have a non-slip finish and be free of loose material (e.g., gravel, sand), water, and ice. Sand may be used on walkways during ice and snow conditions. All walking surfaces and other play surfaces should be free of holes and abrupt irregularities in the surface. Slippery and uneven walking surfaces can lead to injury even during activities of children and adults that do not involve play. CFOC 4th ed. Standard 5.1.6.4 p.p. 223.

**Compliance Guidelines**
• All indoor and outdoor building areas and structures must be in good repair. This includes all indoor and outdoor play equipment and inside and outside entrances, exits, steps, and walkways used by children.
• The provider must ensure that no play equipment or equipment component could fail or otherwise cause injury from inadequate maintenance such as:
  - Missing, bent, broken, or worn out components
  - Loose hardware or missing nuts or bolts
  - Excessive wear on any part of the equipment
  - Rusted or corroded metal
  - Wood that is rough or splintery
• If equipment is in a state of disrepair and is no longer sturdy or safe, it should be made inaccessible to children until it can be fixed or discarded.
• When hooks, such as C hooks, are open to the point that equipment could come out of the gap, the equipment will be considered not to be maintained in good repair.
• During and immediately after a snowstorm, the provider will be allowed a reasonable amount of time to remove snow from outdoor exit areas, stairs, and walkways to prevent a buildup of snow and ice.
  - In case of emergencies, all walkways, exits, and stairways must be free of ice and snow even if the children will not be going outside.
  - Walkways must be cleared to a width of at least 3 feet and for a distance of at least 6 feet from the building.

**Risk Level**

**High**

**Corrective Action for 1st Instance**
Citation and CMP Warning when:
• Children were exposed to asbestos.
• A child is unable to use a toilet or handwashing sink when necessary due to equipment failure or breakdown.
• The only toilet in the facility was broken while children were in care and the toilet was not repaired immediately (within one hour). Refer to 50-9(11).

**Risk Level**

**Moderate**

**Corrective Action for 1st Instance**
Citation Warning when:
• The presence of asbestos was not immediately corrected, but children were not exposed.
• Lack of maintenance could cause equipment failure.
• There is a buildup of ice in entrances, exits, steps, and walkways used by children.
• There is a missing step or unstable stairs that must be used to enter the facility or access the outdoor area.

**Risk Level**

**Low**
**Corrective Action for 1st Instance**
Warning for other hazards that require maintenance including:
- Exposed fiberglass insulation
- Heat vents that are missing covers
- Cracked or damaged flooring that could cause tripping
- Leaking plumbing (with the exception of a leaking faucet)
- An exposed fluorescent light tube with no covering on the fixture
- Draperies, blinds, or other window coverings that require maintenance including torn draperies or broken blinds that a child could become entangled in
- Wooden equipment that is rough or has splinters
- Cracks in equipment that could pinch a child's skin

(16) **The provider shall ensure that accessible raised decks or balconies that are five feet or higher, and open stairwells that are five feet or deeper have protective barriers that are at least three feet high.**

**Rationale/Explanation**
Children falling from elevated play areas may suffer fatal head injuries. CFOC 4th ed. Standard 6.1.0.4 p.p. 285.

**Compliance Guidelines**
- When there is a lip on the edge of the stairwell, the depth is measured from the top of the lip down to the bottom of the stairs.
- Barriers need to be at least three feet (36 inches) high measured from the surface from which a person could fall.
- Barriers on accessible raised decks or balconies that are five feet or higher cannot have gaps that are greater than 5 inches by 5 inches. Licensors will measure gaps with a gap-measure tool.

**Risk Level**
High

**Corrective Action for 1st Instance**
Citation and CMP Warning when:
A deck or balcony that is five feet or higher or an open basement stairwell that is five feet or deeper has no protective barrier.

**Risk Level**
Moderate

**Corrective Action for 1st Instance**
Citation Warning when:
- A required protective barrier has a gap that is five by five inches or greater in diameter.
- A required protective barrier is under three feet high but is at least 24 inches.

**Risk Level**
High
Corrective Action for 1st Instance
Citation and CMP Warning when:
No barrier, or barrier is under 24 inches

(17) If the facility is subdivided, any part of the building is rented out, or any area of the facility is shared including the outdoor area, the department may inspect the entire facility and the provider shall ensure that covered individuals in the facility comply with the rules, except when the following conditions are met:
   (a) there is a signed rental or lease agreement for the rented area;
   (b) there is a separate mailing address for the rented area;
   (c) there is a separate entrance for the child care program;
   (d) there are no connecting interior doorways that can be used by unauthorized individuals; and
   (e) there is no shared access to the outdoor area, unless a qualified caregiver is with the children each time children in care are using the outdoor area.

Rationale/Explanation
It is essential that any area on the provider’s premises must be a safe and healthy environment when accessible to children. This includes rooms, offices, and other areas that are occupied by others, but can be accessed by children in care.

Compliance Guidelines
• Addresses on the mailboxes or on mail that is addressed to each person will confirm that the provider and the renter have separate addresses.
• If the outdoor area can be accessed or shared by residents, no children may be in the outdoor area without the provider or a caregiver.
• When all of the requirements of this rule are met:
   - CCL is not required to inspect the parts of the house that are subdivided and/or rented out, and
   - The occupants in the subdivided or rented part of the facility are not required to have background checks.
• If any of the above requirements are not met, CCL will:
   - Inspect the entire facility including areas that may be subdivided, rented out, or shared.
   - Verify in the CCL App that all covered individuals in the facility have passed a background check.

Risk Level & Corrective Action for 1st Instance
The corrective action will be based on the severity of harm that was caused or likely to be caused as a result of a rule violation.

(18) If there is an outdoor area used by children in care, the provider shall comply with Subsections R430-50-9(19) through R430-50-9(24).
The provider shall ensure that the outdoor area is safely accessible to children.

**Rationale/Explanation**
The facility or home should be equipped with an outdoor play area that directly adjoins the indoor facilities or that can be reached by a route that is free of hazards. CFOC 4th ed. Standard 6.1.0.1 p.p. 282.

**Compliance Guidelines**
- In order to be licensed, there must be an outdoor area on the provider’s premises that can be safely reached and used by the children. Facilities that do not have outdoor areas on site cannot ensure that children in their care are playing on equipment or in a space that is safe. Because open air is vital for children, indoor space cannot replace outdoor space.
- Any outdoor area that is used by children, including front yards, must adequately protect children from vehicular traffic.
- The route from the house to the outdoor area must be safe. For example, an outdoor area is not safely accessible if children must walk across an unsafe deck (such as one with broken boards or holes in it) or cross a driveway where cars or other motor vehicles come and go.
- The following examples of outdoor areas that are safely accessible include:
  - An outdoor area that is directly adjacent to the house, so that children exit the house straight into the play area.
  - A large, open-air deck that children access directly from the house as long as the deck has the required space per child and meets other licensing requirements.
  - An outdoor area on the premises that is reached by way of a fenced walkway.
  - When the building and entire outdoor area are surrounded by fencing, as long as the area inside the fence does not have motor vehicles or other hazards.
  - A common area in a multi-home complex as long as a caregiver is always with the children, the area can be safely reached, and portable fencing is set up around the area each time the children are outside.

**Risk Level**
Moderate

**Corrective Action for 1st Instance**
Citation Warning

The provider shall ensure that the outdoor area has at least 40 square feet of space for each child using the area at one time.

**Rationale/Explanation**
Play areas must be sufficient to allow freedom of movement without collisions among active children. Providing more square feet per child may correspond to a decrease in the number of injuries associated with gross motor play equipment. In addition, meeting proposed Americans with Disabilities Act (ADA) outdoor play area requirements for accessible routes, and developing natural, outdoor play yards with variety and shade can only be achieved if sufficient outdoor play space is provided. CFOC 4th ed. Standard 6.1.0.1 p.p. 283.
Compliance Guidelines

• The outdoor space that will be used by the children ages 0-12 years (including the provider’s and employees’ own children who will attend the program):
  - Must meet the square footage requirements of this rule.
  - Is a factor in determining the maximum capacity of the facility.
• After the outdoor area is measured at the Pre-License Inspection, generally the space is not remeasured on subsequent inspections except when:
  - The facility's outdoor area has been renovated or changed.
  - A provider requests a change to their capacity.
  - The outdoor play area appears overcrowded during an inspection.
• A facility may have more than one outdoor area, as long as each area is safely accessible, fenced as required, meets the square footage requirements for the number of children using the area, and is in compliance with other licensing rules.

Risk Level
Moderate

Corrective Action for 1st Instance
Citation Warning

(21) The provider shall ensure that the outdoor area is enclosed within a fence, wall, or solid natural barrier that is at least four feet high if the facility is on a street or within a half mile of a street that:
  (a) has a speed of 25 miles per hour or higher; or
  (b) has more than two lanes of traffic.

Rationale/Explanation
This standard helps to ensure proper supervision and protection, prevention of injuries, and control of the area. An effective fence is one that prevents a child from getting over, under, or through it and keeps children from leaving the fenced outdoor play area, except when supervising adults are present. Although fences are not childproof, they provide a layer of protection for children who stray from supervision. CFOC 4th ed. Standard 6.1.0.8 p.p. 286-287.

Compliance Guidelines

• The entire perimeter of the fence must be at least four feet (48 inches) high.
• The fence must be measured on each side at its lowest point, from the side the children play on, and includes measuring a gate.
• If a fence or wall was previously approved by CCL, then the barrier’s height is considered in compliance as long as:
  - The barrier has not been replaced, repaired, or altered; and
  - All areas of the barrier measure within five inches of the required four foot height. This five inch allowance only applies to a previously-approved barrier that has not changed since the approval; it does not apply to barriers formed by bushes or shrubs, etc. If the
fence or wall was replaced, repaired, adjusted, or it has changed since the last CCL inspection, it must meet the four foot height requirement.

- It is not a rule violation if a fence is lower than 48 inches in height due to temporary weather conditions, such as snow on the ground at the base of the fence.
- Bushes will be considered a natural barrier when there are no gaps five by five inches or greater.
- When a ramp (leading to the outdoor area) is separated from the area with a four foot high gate that is closed, the height of a fence on the ramp does not need to be assessed. If there is no gate, the gate is open, or is less than four feet high, then the fence on the perimeter of the ramp (that encloses the ramp and outdoor area) must be at least four feet high. The interior fencing on the ramp does not need to be assessed.
- Interior fences within the four foot perimeter fence do not need to be 48 inches high, unless otherwise required in rule.
- Any temporary fencing that is used to comply with this rule must:
  - Always be set up when children are in the outdoor area.
  - Meet the fencing height requirements as described above.

**Risk Level**

High

**Corrective Action for 1st Instance**

Citation and CMP Warning when:

There is no fence or barrier enclosing the outdoor area, or an area of the fence or barrier is less than 36 inches high.

**Risk Level**

Moderate

**Corrective Action for 1st Instance**

Citation Warning when:

An area of the fence or barrier is less than 48 inches high.

(22) The provider shall ensure that the following hazards are separated from the children's outdoor area with a fence, wall, or solid natural barrier that is at least four feet high:

(a) barbed wire that is within 30 feet of the children's play area;
(b) livestock on or within 50 yards of the property line;
(c) dangerous machinery, such as farm equipment, on or within 50 yards of the property line;
(d) a drop-off of more than five feet on or within 50 yards of the property line; and
(e) a water hazard, such as a swimming pool, pond, ditch, lake, reservoir, river, stream, creek, or animal watering trough, on or within 100 yards of the property line.

**Rationale / Explanation**

The outdoor play area should be enclosed with a fence or natural barriers. CFOC 4th ed. Standard 6.1.0.8. p.p. 286.

**Compliance Guidelines**
• A drop-off of 5 feet or more is assessed by measuring from the top of the drop-off straight down to where an object or person would fall.
• Dangerous machinery includes active railroads.
• Any swimming pool, pond, ditch, lake, river, stream, creek, or animal trough watering with water that pools 2 inches or deeper will be considered a hazard.

**Risk Level**
High

**Corrective Action for 1st Instance**
Citation and CMP Warning when:
There is no fence or barrier separating the outdoor area from a hazard as required, or an area of the fence or barrier is less than 36 inches high.

**Risk Level**
Moderate

**Corrective Action for 1st Instance**
Citation Warning when:
An area of the fence or barrier is less than 47 inches high.

(23)  The provider shall ensure that there is no gap five by five inches or greater in or under the fence or barrier.

**Rationale/Explanations**
Fences and barriers should not prevent the observation of children by caregivers/teachers. If a fence is used, it should conform to applicable local building codes in height and construction. CFOC 4th ed. Standard 6.1.0.8 p.p. 286.

**Compliance Guidelines**
• The entire perimeter of all required fences and barriers must be checked for gaps, including fences enclosing the outdoor area and any interior fences required to separate children from hazards even if previously approved.
• The size of any gap in or under the fence should be measured without pushing on the fence. Licensors will use a gap-measure tool.
• Depending on the purpose of the fence, it is a violation of rule 90-9(15) or 90-9(16) for not having a fence if any gap is 3 feet or greater in size.

**Risk Level**
High

**Corrective Action for 1st Instance**
Citation and CMP Warning when:
Any required fence or barrier has a five by five inch gap or greater that is lower than 36 inches.

**Risk Level**
Moderate
Corrective Action for 1st Instance
Citation Warning when:
Any required fence or barrier has a five by five inch gap or greater that is 36 inches or higher.

(24) The provider shall ensure that there is shade available to protect the children from excessive sun and heat when children are in the outdoor area.

Rationale/Explanation
The shade will provide comfort and prevent sunburn or burning because the structures or surfacing are hot. Access to sun and shade is beneficial to children while they play outdoors. Light exposure of the skin to sunlight promotes the production of vitamin D that growing children require for bone development and immune system health. Additionally, research shows sun may play an important role in alleviating depression. Exposure to the sun is needed, but children must be protected from excessive exposure. Individuals who suffer severe childhood sunburns are at increased risk for skin cancer. Practicing sun-safe behavior during childhood is the first step in reducing the chances of getting skin cancer later in life. CFOC 4th ed. Standard 6.1.0.7 p.p. 286.

Children have a greater surface area to body mass ratio than adults. Therefore, children do not adapt to extremes of temperature as effectively as adults when exposed to a high climatic heat stress or to cold. Children produce more metabolic heat per mass unit than adults when walking or running. They also have a lower sweating capacity and cannot dissipate body heat by evaporation as effectively, CFOC 4th ed. Standard 3.1.3.2 p.p. 99.

Compliance Guidelines
• There must be a provision for shade whenever the children are in the outdoor area, and it must be provided year-round.
• Shade can come from a tree, awning, patio roof, or other structure such as the side of the building. A canopy or umbrella may be used as long as it can be set up and stand on its own.
• There is no rule about the time of day that children play outside as long as shade is available to the children.

Risk Level
Moderate

Corrective Action for 1st Instance
Citation Warning when:
Shade is not provided when children are in the outdoor area and the temperature is 65 degrees or above.

Risk Level
Low

Corrective Action for 1st Instance
Warning when:
Shade is not provided when children are in the outdoor area and the temperature is below 65 degrees.
The rules in this section regulate the caregiver-to-child ratio which is the maximum number of children each caregiver may be responsible for. The rules also limit group size meaning the number of children being cared for in one group at the same time. These rules are based on what children need for quality nurturing care.

Rules regarding the caregiver-to-child ratio and group size apply any time there are children in care, including when children are being transported and during offsite activities. The rules also apply during special activities when child care is provided at the facility, such as Parents’ Night Out or Saturday party.

### Does the Child Count in the Caregiver-to-Child Ratio?

<table>
<thead>
<tr>
<th>Child's Age</th>
<th>Unrelated Child</th>
<th>Provider's Own Child</th>
<th>Caregiver's Own Child</th>
<th>Other Related Child</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-3 years</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>4 years and older</td>
<td>Yes</td>
<td>No*</td>
<td>No*</td>
<td>Yes</td>
</tr>
</tbody>
</table>

### Does the Child Count in Maximum Group Size

<table>
<thead>
<tr>
<th>Child's Age</th>
<th>Unrelated Child</th>
<th>Provider's Own Child</th>
<th>Caregiver's Own Child</th>
<th>Other Related Child</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-3 years</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>4 years - 12 years</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>13 years old and older</td>
<td>Yes (if special needs)</td>
<td>No</td>
<td>No</td>
<td>Yes (if special needs)</td>
</tr>
</tbody>
</table>

*The provider's and caregiver’s children who are 4 years old and older do not count in the caregiver-to-child ratio as long as the provider or caregiver is working at the facility or performing work-related duties.

Refer to the following guidelines:

- The rules are assessed according to the number of qualified children present and not by the number of children who are enrolled.
- Non-qualifying children (Ex. Friends of the provider's children and other visiting children younger than 13 years of age) who are present during child care hours and not accompanied by their parents or adult caregiver count in the maximum group size. They also count in the caregiver-to-child ratio if they are younger than four years of age.
- It is a rule violation if the group size is exceeded. The provider can correct this rule violation by having the number of visiting children that put them over the group size leave the facility.
• It is a rule violation if the ratios are exceeded. The provider can correct this rule violation by having the number of visiting children that put them over the ratio leave the facility.
• For an individual to count in the caregiver-to-child ratio, they must:
  - Meet personnel requirements as specified in rule,
  - Be on the premises or in the offsite area where the children are being cared for, and
  - Be performing caregiving duties.

45 Minute Allowance
For unforeseen circumstances, the caregiver-to-child ratio may be out of compliance for up to 45 minutes. Examples of unforeseen circumstances include:
• A caregiver does not arrive at their scheduled time.
• Children arrive earlier or depart later than their normal time without advance notification from their parent.
• A caregiver needs to leave due to an emergency.
• A caregiver leaves their employment without advance notice or is dismissed for immediate cause.

To remain in compliance with ratios during unforeseen circumstances, refer to the following guidelines:
• The provider must address the situation as soon as it is known that ratios will be out of compliance due to an unforeseen circumstance. The intent of the 45 minutes is to allow enough time for an approved individual to arrive and place the facility back into ratio.
• Children must not be left unsupervised.
• Sign-in and sign-out records must be up-to-date and available for review by CCL.
• If licensing staff arrive when ratios are out of compliance, but the ratio is brought into compliance within the 45 minute allowance, it will not be considered a rule violation. Instead:
  - Two Focus Inspections will be conducted to confirm that it was an unforeseen circumstance.
  - If ratios are out of compliance at the first Focus Inspection, a corrective action will be issued and the second Focus Inspection will not be conducted. Instead, a Followup Inspection will be conducted to verify correction is maintained.
  - If ratios are in compliance at the first and second Focus Inspections, no corrective actions will be issued, but the situation will be documented in the CCL App.
• It is a rule violation if the ratio is not brought into compliance within the 45 minutes.

Emergency Substitute Rule Variance
When the caregiver-to-child ratio is out of compliance because a caregiver unexpectedly left, and the provider cannot come into compliance within 45 minutes, CCL may grant an Emergency Substitute Rule Variance to the emergency substitute rules for up to ten working days. This will give the provider time to use an emergency substitute longer than 24 hours until they bring in a new caregiver in order to be in compliance with ratios. This variance will also allow for the use of a 16 or 17-year-old emergency substitute.

To obtain this variance, the provider must:
• Contact their licensor within 24 hours (or contact other CCL staff if the licensor is unavailable), and
• Give CCL the name and/or the Covered Individual Number of the person who left.
Refer to the following guidelines:

• The provider must maintain compliance with supervision rules. A variance for supervision will not be granted.
• All emergency substitutes must sign a written statement that they:
  - Have not been convicted of a felony or misdemeanor;
  - Do not have a substantiated background finding; and
  - Are not being investigated for abuse or neglect by any federal, state, or local government agency.
• The emergency substitute’s written statement must be submitted to CCL within 5 working days after the occurrence.
• An emergency substitute may not be left unsupervised until they have met the requirements to become a caregiver.
• A Focus Inspection will be conducted to verify compliance with ratios after the variance expires.

(1) The provider shall maintain at least one caregiver for up to eight children in care.

Rationale/Explanation
Low child:staff ratios are most critical for infants and toddlers (birth to thirty-six months). Infant and child development and caregiving quality improves when group size and child:staff ratios are smaller. Improved verbal interactions are correlated with lower child:staff ratios. Small ratios are very important for young children’s development. The recommended group size and child:staff ratio allow three- to five-year-old children to have continuing adult support and guidance while encouraging independent, self-initiated play and other activities. CFOC 4th ed. Standards 1.1.1.1 p.p. 4-5.

Compliance Assessment
• When determining ratio compliance, include:
  - All children younger than 4 years old,
  - Children 4 to 13 years old who are not the provider or an employee’s child, and
  - Any child with a disability who is younger than 18 years old.

Risk Level
High
Corrective Action for 1st Instance
Citation and CMP Warning when:
• There are infants or toddlers in care and it is over ratio by any number of children.
• With 1 caregiver, there are no infants or toddlers in care and it is over ratio by 3 or more children.
• With 2 caregivers, there are no infants or toddlers in care and it is over ratio by 5 or more children.
• A group is over ratio by any number of children during transportation or offsite activities.

Risk Level
Moderate
Corrective Action for 1st Instance
Citation Warning when:
• With 1 caregiver, there are no infants or toddlers in care and it is over ratio by 2 children.

Risk Level
Low

Corrective Action for 1st Instance
Warning when:
• With 1 caregiver, there are no infants or toddlers in care and it is over ratio by 1 child.
• When the provider exceeded the ratios because of visiting children, and the provider had the number of visiting children that put them over the ratio leave the facility during the inspection.

(2) The provider shall ensure that there are no more than two children younger than two years old in care including the provider's and employee's own children.

Rationale / Explanation
Direct, warm social interaction between adults and children is more common and more likely with lower child:staff ratios. Low child:staff ratios are most critical for infants and toddlers (birth to thirty-six months). CFOC 4th ed. Standards 1.1.1.1. p.p. 5.

Compliance Assessment
• The Utah State Legislature passed H.B15S02: Child Care Amendments in the 2022 Legislative Session. Child Care Licensing is updating its rule to reflect the current law. The below compliance guidelines are in line with HB15S02.
  - When caring for children younger than two years old, the provider shall ensure that:
    a) there is at least one caregiver for up to 8 children in the group and there are not more than 2 children under 18 months old in the group, and no more than 3 children under the age of two.
    b) once the group has exceeded 3 under the age of two, there is an additional caregiver for every 2 children under 18 months old in the group, or 3 children under the age of two.

A caregiver may care for no more than **3 children under the age of two**.
At least 1 of the children under 2 years old must be at least 18 months old.

![Diagram of child care group sizes]

5 + 2 + 1 = 8
(3) The provider shall include the provider's and employees' children age four years old or older in care:
  (a) in the group size when the parent of the child is working at the facility; and
  (b) in the group size and the caregiver-to-child ratio when the parent of the child is not working at the facility.

**Compliance Assessment**

The provider's and caregivers' children who are 4 years old and older count in the caregiver-to-child ratio when the provider or a caregiver leaves the premises or the offsite area where children are being cared for and is no longer performing caregiving duties. Ratios must be maintained, even during school runs.
This section explains the rules regarding the supervision and security of the children.

Supervision is basic to safety and the prevention of injury and maintaining quality child care. Parents/guardians have a contract with caregivers/teachers to supervise their children. CFOC 4th ed. Standard 2.2.0.1 p.p. 68.

Supervision rules apply to all children in care. This includes the provider’s and employees’ children younger than 4 years old when those children are with other qualifying children while on the premises, being transported, or participating in offsite activities.

Do Supervision Rules Apply to the Child?

<table>
<thead>
<tr>
<th>Child’s Age</th>
<th>Unrelated Child</th>
<th>Provider’s Own Child</th>
<th>Caregiver’s Own Child</th>
<th>Other Related Child</th>
</tr>
</thead>
<tbody>
<tr>
<td>Younger than 4 years old</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>4 years and older</td>
<td>Yes</td>
<td>No*</td>
<td>No*</td>
<td>Yes</td>
</tr>
</tbody>
</table>

*The supervision rules do not apply to the provider’s and caregiver’s children who are four years old and older, as long as the provider or caregiver is working at the facility or performing work-related duties.

Refer to the following guidelines:
- Supervision means having awareness of and responsibility for each child, and being near enough to intervene as needed.
- Any individual who counts in the caregiver-to-child ratio is responsible for the supervision and security of the children.
- It is a lack of supervision if any child is left in the care of an individual younger than 16 years old. Individuals who are 16 or 17 years old may be caregivers, but may not be left alone with a child in care on the premises, in vehicles, or during offsite activities.
- All supervision rules apply to the provider’s and caregivers’ qualifying children while in care at the facility, during transportation, and during offsite activities.
- It is not a lack of supervision if the provider or caregiver gives permission for their own children to leave the premises in the company of another person (including a sibling).

(1) The provider shall ensure that caregivers provide and maintain active supervision of each child, including:
(a) a caregiver is inside the home when a child in care is inside the home;
(b) a caregiver is in the outdoor area when a child younger than five years old is in the outdoor area;
(c) caregivers know the number of children in their care at any time; and  
(d) caregivers' attention is focused on the children and not on caregivers' personal interests.

Rationale/Explanation
Caregivers/teachers should directly supervise infants, toddlers, and preschoolers by sight and hearing at all times, even when the children are going to sleep, napping or sleeping, are beginning to wake up, or are indoors or outdoors. Children who are presumed to be sleeping might be awake and in need of adult attention. A child's risk-taking behavior must be detected and illness, fear, or other stressful behaviors must be noticed and managed. School-age children should be within sight or hearing at all times. Children are going to be more active in the outdoor learning/play environment and need more supervision rather than less outside. CFOC 4th ed. Standard 2.2.0.1 p.p. 68.

Supervision is basic to safety and the prevention of injury and maintaining quality child care. CFOC 4th ed. Standard 2.2.0.1 p.p. 68.

Regular counting of children (name to face) will alert the staff to begin a search before the child gets too far, into trouble, or slips into an unobserved location. Caregivers/teachers should do the counts before the group leaves an area and when the group enters a new area. The facility should assign and reassign counting responsibility as needed to maintain a counting routine. CFOC 4th ed. Standard 2.2.0.1 p.p. 69.

Compliance Guidelines
• Actively supervising children requires that a caregiver:
  - Knows where each child is at all times.
  - Visually checks (in person) on all awake and sleeping children who are not within the caregiver’s sight at least every 15 minutes. (The use of video and audio monitoring or mirrors does not replace personally checking on children.)
  - Maintains awareness of the entire group of children even when interacting with small groups or individual children.
  - Is primarily focused on the children even when performing a personal task (such as visiting with another adult, talking on the phone, text messaging, reading, lesson planning, taking a bathroom break, or performing other tasks unrelated to child care). It is a rule violation, if a personal task, such as texting or talking on a cell phone, interferes with a caregiver’s active supervision of the children.
• When supervising the children, a caregiver may not engage in the following types of activities:
  - Napping, including when the children are napping
  - Taking a shower or bath
  - Leaving the home to pick up the mail or for other reasons unrelated to child care
  - Performing the tasks of a secondary business (For example a tax business, a beauty salon, a shop, etc.).
• When the children are indoors, the caregiver may briefly (5 minutes or less) go outside to perform a legitimate child care task. Legitimate child care tasks include:
- Taking trash to an outdoor garbage bin
- Conducting a quick observation to prevent hazards before children's use of the outdoor play area
- Emptying or filling up a wading pool after or before use
- Situating play equipment before children use it

The following guidelines apply to active supervision when children are outdoors:
- A caregiver must be outdoors and positioned in a place where they are able to see each child.
- Children in care may ride bikes outside of the fenced area but still on the provider's property if a caregiver is in the same area with the children. The caregiver cannot be inside a fenced area (even with the gate open) if children are outside of the fenced area.
- When children younger than 5 years old are in the outdoor area, the caregiver may leave them outside and go inside for only two reasons: 1) to help a child use the bathroom if needed, and 2) to administer first aid to an injured child. Leaving the children unsupervised for one of these reasons is allowed on condition that:
  - The caregiver takes the children who are younger than 2 years old with them inside,
  - The outdoor area is completely fenced,
  - There is no other caregiver at the facility who can remain outside with the children, and
  - The children are not left outside for longer than 5 minutes.
- It is out of compliance if children younger than 5 years old are left unsupervised outside while the caregiver answers the door (even for licensing staff).
- When there are two caregivers on the premises, at least one caregiver must be in the outdoor area with the children who are younger than 5 years old while the other caregiver is performing caregiving duties.
- When outside, children age three or older may be sent indoors to use the bathroom without the caregiver, but only one child at a time may be sent in order to prevent multiple children from being inside without supervision and to ensure that the caregiver knows where every child is.

**Risk Level**

**Extreme**

**Corrective Action for 1st Instance**

Citation and CMP
- If lack of supervision results in:
  - A lost child
  - A child being left on an offsite activity
  - A child being left unattended in a vehicle
  - A child is left unsupervised at a pool
  - A child being left at the home without a caregiver

**Risk Level**

**High**

**Corrective Action for 1st Instance**

Citation and CMP Warning when:
• An exterior door is left open without a caregiver in the room allowing children to exit the facility without supervision.
• A caregiver was unable to accurately account for all of the children, including in an emergency evacuation.
• Any child is left in the care of an individual younger than 16 years old. (Individuals who are 16 or 17 years old may be caregivers, but may not be left alone with a child in care on the premises, in vehicles, or during offsite activities).

**Risk Level**
Moderate

**Corrective Action for 1st Instance**
Citation Warning otherwise

(2) The provider shall ensure that staff and household members who are 16 or 17 years old only have unsupervised contact with any child in care, including during offsite activities and transportation when:
   (a) the provider or an eligible adult is physically present and available as needed; and
   (b) they are not volunteers.

**Rationale / Explanation**
School-age children should be within sight or hearing at all times. Children like to test their skills and abilities. This is particularly noticeable around playground equipment. Even if the highest safety standards for playground layout, design and surfacing are met, serious injuries can happen if children are left unsupervised. CFOC 4th ed. Standard 2.2.0.1. p.p. 68.

**Compliance Guidelines**
Although school-age children may be allowed to play outdoors while a caregiver is indoors, they may not be allowed to play indoors when the only caregiver is outdoors.

**Risk Level**
High

**Corrective Action for 1st Instance**
Citation and CMP Warning

(3) The provider shall ensure that staff, volunteers, and household members who are younger than 16 years old are not assigned to care for or supervise any child in care.

**Compliance Guidelines**
• An individual who is assigned to protect the health and safety of children is a caregiver. This includes any individual who is expected to count in the caregiver-to-child ratio, meet the physical or emotional needs of the children, including diapering, toileting, feeding, or protecting them from harm; or supervise children must meet all caregiver requirements listed in Section 7, Rule 9.
• Individuals who are younger than 16 years old are not approved to be caregivers.
   - It is a lack of supervision if a child is left in the care of an individual younger than 16 years old.
(4) The provider shall ensure that guests do not have unsupervised contact with any child in care, including during offsite activities and transportation.

**Compliance Guidelines**
A guest may not be alone in a room or area with any child in care. A caregiver or other employee who is at least 18 years old and has passed a CCL background check must be in the same room or area.

**Risk Level**
High

**Corrective Action for 1st Instance**
Citation and CMP Warning

(5) The provider shall ensure that parents of children in care do not have unsupervised contact with any child in care, except with their own children.

**Compliance Guidelines**
If a parent is employed at the child care facility, they must have a background check and meet other personnel requirements as stated in rule.

**Risk Level**
High

**Corrective Action for 1st Instance**
Citation and CMP Warning

(6) The provider may allow school-age children to be outdoors while caregivers are indoors if:
   (a) caregiver can hear the children when children are outdoors; and
   (b) the children are in an area completely enclosed within a fence, wall, or solid natural barrier that is at least four feet high.

**Rationale / Explanation**
School-age children should be within sight or hearing at all times. Children like to test their skills and abilities. This is particularly noticeable around playground equipment. Even if the highest safety standards for playground layout, design and surfacing are met, serious injuries can happen if children are left unsupervised. CFOC 4th ed. Standard 2.2.0.1. p.p. 68.

**Compliance Guidelines**
Although school-age children may be allowed to play outdoors while a caregiver is indoors, they may not be allowed to play indoors when the only caregiver is outdoors.

**Risk Level**
High

**Corrective Action for 1st Instance**
(7) The provider shall ensure that a caregiver monitors each sleeping infant by:
   (a) placing each infant to sleep within the sight and hearing of a caregiver; or
   (b) personally observing each sleeping infant at least once every 15 minutes.

Rationale/Explanation
Caregivers/teachers should directly supervise infants, toddlers, and preschoolers by sight and hearing at all times, even when the children are going to sleep, napping or sleeping, are beginning to wake up, or are indoors or outdoors. CFOC 4th ed. Standard 2.2.0.1. p.p. 68

Safe sleep practices help reduce the risk of sudden unexpected infant deaths (SUIDs). Facilities should develop a written policy describing the practices to be used to promote safe sleep for infants. The policy should explain that these practices aim to reduce the risk of SUIDs, including sudden infant death syndrome (SIDS), suffocation and other deaths that may occur when an infant is in a crib or asleep. About 3,500 SUIDs occurred in the U.S. in 2014. Despite the decrease in deaths attributed to sleeping practices and the decreased frequency of prone (tummy) infant sleep positioning over the past two decades, some caregivers/teachers continue to place infants to sleep in positions or environments that are not safe. Most sleep-related deaths in child care facilities occur in the first day or first week that an infant starts attending a child care program. CFOC 4th ed. Standard 3.1.4.1. p.p. 102-103.

Compliance Guidelines
- When checking on a sleeping infant, the caregiver must:
  - Ensure the child is breathing.
  - Remove and/or correct any potential hazards to ensure the child's safety, such as adjusting a blanket from covering an infant's head.
- A caregiver may use an enclosed porta-crib as long as the porta-crib window and top remain open so that the child can be visually checked.
- Monitors may be used in addition to supervising children but do not replace the requirement to personally observe each sleeping infant every 15 minutes.

Risk Level
High

Corrective Action for 1st Instance
Citation and CMP Warning

(8) The provider may allow a child to participate in supervised offsite activities without a caregiver if:
   (a) the provider has prior written permission from the child's parent for the child's participation; and
   (b) the provider has clearly assigned the responsibility for the child's whereabouts and supervision to a responsible adult who accepts that responsibility throughout the
period of the offsite activity.

**Rationale/Explanation**
School-age children should be permitted to participate in activities off the premises with appropriate adult supervision and with written approval by a parent/guardian and by the caregiver. If parents/guardians give written permission for the school-age child to participate in off-premises activities, the facility would no longer be responsible for the child during the off-premises activity and not need to provide staff for the off-premises activity. CFOC 4th ed. Standard 2.2.0.1. p.p. 68-69.

**Compliance Guidelines**
- To be in compliance with this rule, the provider must have the parent's prior written permission that includes:
  - A description of the specific offsite activity in which the child may participate.
  - The specific days and times when the child may participate in the offsite activity.
  - The name of the adult who will be responsible for and supervise the child while offsite.
  - A statement releasing the provider from liability while the child participates in an offsite activity.
- Examples of supervised offsite activities include music lessons, dance lessons, sports practices or playing at a friend's house.

**Risk Level**
High

**Corrective Action for 1st Instance**
Citation and CMP Warning when:
- The provider allows a child to leave without parental permission.
- The provider did not assign responsibility for the child to a responsible adult.

(9) **The provider shall ensure that parents have access to their child and the areas used to care for their child when their child is in care.**

**Rationale/Explanation**
Requiring unrestricted access of parents/guardians to their children is essential to preventing the abuse and neglect of children in child care. When access is restricted, areas observable by the parents/guardians may not reflect the care the children actually receive. CFOC 4th ed. Standard 2.3.1.2 p.p. 81-82.

**Compliance Guidelines**
- If the facility's doors are locked for security reasons, the provider must have a way to allow authorized parents to enter in a timely manner.
- Although not required by CCL, a common way of securing a child care facility while allowing immediate access to parents include:
  - Using a keypad system in which parents can enter a code or use a fingerprint.
To maintain security and supervision of children, the provider shall ensure that:
(a) each child is signed in and out;
(b) only parents or individuals with written authorization from the parent may sign-out a child;
(c) photo identification is required if the individual signing the child out is unknown to the provider;
(d) individuals signing children in and out use identifiers, such as a signature, initials, or electronic code;
(e) the sign-in and sign-out records include the date and time each child arrives and leaves; and
(f) there is written permission from the child’s parent if school-age children sign themselves in or out.

Rationale/Explanation
The facility should have a sign-in/sign-out system to track who enters and exits the facility. This system helps to maintain a secure environment for children and staff. It also provides a means to contact visitors if needed (such as a disease outbreak) or to ensure all individuals in the building are evacuated in case of an emergency. CFOC 4th ed. Standard 9.2.4.7 p.p. 400.

Releasing a child into the care of an unauthorized person may put the child at risk. If the caregiver/teacher does not know the person, it is the caregiver/teacher’s responsibility to verify that the person picking up the child is authorized to do so. This requires checking the written authorization in the child’s file and verifying the identity of the person. CFOC 4th ed. Standard 9.2.4.8 p.p. 400-401.

Accurate record keeping also aids in tracking the amount (and date) of service for reimbursement and allows for documentation in the event of child abuse allegations or legal action involving the facility CFOC 4th ed. Standard 9.2.4.10 p.p. 401-402.

Compliance Guidelines
• There must be a separate signature for each time a child is signed in and for each time a child is signed out.
• Rule requires that anyone signing a child out of child care has the parent’s written authorization. This authorization is not required when signing a child into the child care facility.
• The person signing a child out must use their own signature or identifier, not the signature of the parent.
• The provider may accept an electronic permission statement (such as an email or text message) from the parent for an individual to sign out their child as long as the caregiver can confirm the sender’s identity.
• An electronic computer system that uses an identification code to sign children in and out meets the intent of this rule.
• A caregiver may release a child to a person younger than 18 years old as long as the person has written authorization from the child's parent to sign the child out.
• Providers and employees must sign in and out their own qualifying children who are in care.

**Risk Level**
High

**Corrective Action for 1st Instance**
Citation and CMP Warning when:
• An unauthorized person is allowed to take a child from the facility.
• The provider allows a school-age child to sign out of child care without having permission from the parent.

**Risk Level**
Low

**Corrective Action for 1st Instance**
Warning otherwise

**Rationale/Explanation**
In an emergency, the provider shall accept the parent’s verbal authorization to release a child when the caregiver can confirm the identity of:
(a) the individual giving verbal authorization, and
(b) the individual picking up the child.

If there is an extenuating circumstance (e.g., the parent/guardian or other authorized person is not able to pick up the child), another individual may pick up a child from child care if they are authorized to do so by the parent/guardian in authenticated communication such as a witnessed phone conversation in which the caller provides pre-specified identifying information or writing with pre-specified identifying information. The telephone authorization should be confirmed by a return call to the parents/guardians. The facility should establish a mechanism for identifying a person for whom the parents/guardians have given the facility prior written authorization to pick up their child, such as requiring photo ID or including a photo of each authorized person in the child's file. CFOC 4th ed. Standard 9.2.4.8 p.p. 400-401.

**Compliance Guidelines**
In an emergency, a parent may use an electronic means (such as a phone call) as authorization to release their child as long as the caregiver can confirm the sender’s identity.

**Risk Level**
High

**Corrective Action for 1st Instance**
Citation and CMP Warning
This section of rules deals with appropriate methods of guiding and interacting with children and explains the types of interactions that are not allowed. The relationships and interactions between the children and all those involved with them is of utmost importance.

Caregivers/teachers should guide children to develop self-control and appropriate behaviors in the context of relationships with peers and adults. CFOC 4th ed. Standard 2.2.0.6 p.p. 73-74.

(1) The provider shall ensure that no child is subjected to physical, emotional, or sexual abuse while in care.

**Rationale/Explanation**
Properly executed reference checks, as well as in-person interviews, help seek out and prevent possible child abuse from occurring in child care centers. The use of open-ended questions and requests for verbal references require personal conversations and, in turn, can uncover a lot of warranted information about the applicant. CFOC 4th ed. Standard 1.2.0.2 p.p. 10.

**Compliance Guidelines**
CCL will investigate all allegations of child abuse and neglect in child care programs through Complaint Investigations and report suspected abuse or neglect as required by law. A substantiated allegation of abuse or neglect will be on the provider’s public record.

**Risk Level**
High

**Corrective Action for 1st Instance**
Citation and CMP Warning

(2) The provider shall inform parents, children, and those who interact with the children of the center's behavioral expectations and how any misbehavior will be handled.

**Rationale/Explanation**
Children have to be taught expectations for their behavior if they are to develop internal control of their actions. The goal is to help children learn to control their own behavior. Discipline should be an ongoing process to help children learn to manage their own behavior in a socially acceptable manner, and should not just occur in response to a problem behavior. Rather, the adult's guidance helps children respond to difficult situations using socially appropriate strategies. To develop self-control, children should receive adult support that is individual to the child and adapts as the child develops internal controls. CFOC 4th ed. Standard 2.2.0.6. pp. 73-74.

Every child is different, but experts have a clear idea about the range of normal development and
characteristics of children of different ages. Below are examples of typical behaviors of children of different ages.

### Infants: a child younger than 12 months old

<table>
<thead>
<tr>
<th>Behavior Expectations</th>
<th>Positive Guidance</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Cry to communicate that they are hungry, tired, in distress, or have other needs.</td>
<td>• Meet the infant's physical needs</td>
</tr>
<tr>
<td>• They become bored if they do not receive adequate attention or stimulation.</td>
<td>• Allow infants to follow their own sleep and feeding schedule.</td>
</tr>
<tr>
<td>• Being held makes them feel secure.</td>
<td>• Give the infant attention by making eye contact and smiling.</td>
</tr>
<tr>
<td>• Wariness of strangers, and separation anxiety in the later months.</td>
<td>• Acknowledge their feelings.</td>
</tr>
<tr>
<td>• Object permanence is developed around 8 months.</td>
<td>• Infants in stress can be comforted by physical touch. Pick up the child, carry</td>
</tr>
<tr>
<td>• Put everything in their mouths because they explore through taste.</td>
<td>them around the room. Try bouncing or rocking gently.</td>
</tr>
<tr>
<td>• Feel and touch everything because they learn and explore by using their five senses.</td>
<td>• Infants can be comforted by sounds. Try humming, singing or speaking softly.</td>
</tr>
<tr>
<td>• Need physical exercise such as “tummy time.”</td>
<td>• Redirect the infant by moving them to another play area, or changing the toys in</td>
</tr>
<tr>
<td>• Repeating the same actions, saying the same things over and over, curious and eager for interactions.</td>
<td>their area.</td>
</tr>
<tr>
<td>• Engage in solitary play, they are not interested in or able to play with others yet.</td>
<td>• Model how to play with the toys in front of the child.</td>
</tr>
<tr>
<td></td>
<td>• Talk to infants as you interact with them.</td>
</tr>
<tr>
<td></td>
<td>• Ensure they have plenty of space to move and explore safely.</td>
</tr>
<tr>
<td></td>
<td>• Serve and return: The child “serves” by reaching out for interaction—with eye</td>
</tr>
<tr>
<td></td>
<td>contact, facial expressions, gestures, babbling, or touch. A responsive caregiver</td>
</tr>
<tr>
<td></td>
<td>“returns the serve” by speaking back, playing peekaboo, or sharing a toy or a laugh.</td>
</tr>
</tbody>
</table>

### Toddlers: age 12 months to 23 months

<table>
<thead>
<tr>
<th>Behavior Expectations</th>
<th>Positive Guidance</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Put everything in their mouths because they explore through taste.</td>
<td>• Model sharing and proper use of toys and play equipment.</td>
</tr>
<tr>
<td></td>
<td>• Praise the process not the result.</td>
</tr>
<tr>
<td>Behavior Expectations</td>
<td>Positive Guidance</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------------------</td>
<td>-----------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>• Feel and touch everything because they learn and explore by using their five senses.</td>
<td>• Distract the child and redirect by guiding them to another play area or activity.</td>
</tr>
<tr>
<td>• May cry, hit, bite, or throw toys to express their emotions or communicate in general. They do not have the verbal skills to communicate through words yet.</td>
<td>• Maintain a schedule and routine to provide stability and security.</td>
</tr>
<tr>
<td>• May show signs of anxiety during transitions such as parent drop off. This anxiety may look like withdrawing, crying, clinging, and/or wanting to be held.</td>
<td>• Give notice before a transition so the child can prepare and cope with the change.</td>
</tr>
<tr>
<td>• Might be a picky or erratic eater.</td>
<td>• Talk to them in a reassuring voice and empathize with their feelings.</td>
</tr>
<tr>
<td>• Is constantly on the move - running, kicking, climbing or jumping.</td>
<td>• Utilize proximity and active supervision to deescalate a frustrated child.</td>
</tr>
<tr>
<td>• Engage in solitary play, they are not interested in or able to play with others yet.</td>
<td>• Praise and positive reinforcement to encourage desirable behaviors.</td>
</tr>
<tr>
<td>• Evaluate the environment for evidence of overstimulation or crowding.</td>
<td>• Rotate toy selections to maintain interest and appropriate amounts of challenging activities for the children.</td>
</tr>
<tr>
<td>• Ensure they have plenty of space to move and explore safely.</td>
<td>• Include lots of opportunities for movement throughout the day.</td>
</tr>
<tr>
<td>• Rotate toy selections to maintain interest and appropriate amounts of challenging activities for the children.</td>
<td></td>
</tr>
<tr>
<td>• Include lots of opportunities for movement throughout the day.</td>
<td></td>
</tr>
</tbody>
</table>
modeling, timers and planned sharing activities.

- Model and give examples of ways to manage strong feelings.
- Offer limited choices when possible (2-3 options work best).

### Preschoolers: 3-4 year olds

<table>
<thead>
<tr>
<th>Behavior Expectations</th>
<th>Positive Guidance</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Three year old.</strong></td>
<td></td>
</tr>
<tr>
<td>- Temper tantrums peak at this age.</td>
<td>- Label behaviors, not children.</td>
</tr>
<tr>
<td>- Difficulty when separated from caregivers. Children may cry at drop offs, even if they previously came cheerfully.</td>
<td>- Set clear expectations.</td>
</tr>
<tr>
<td>- Can follow simple rules but need reminding.</td>
<td>- Make rules simple and descriptive of what you want to see and hear. For example:</td>
</tr>
<tr>
<td>- Can share but may not like it.</td>
<td>○ Walking feet</td>
</tr>
<tr>
<td>- Begins to show empathy.</td>
<td>○ Gentle hands</td>
</tr>
<tr>
<td>- May tell on others to prove they know the rules.</td>
<td>○ Listening ears</td>
</tr>
<tr>
<td>- Beginning to understand the difference better “mine” and “yours”.</td>
<td>- Physically redirect by removing a problematic object, or moving a child to a different play area.</td>
</tr>
<tr>
<td>- Develops friendships.</td>
<td>- Verbally redirect by asking a child to do something differently. For example:</td>
</tr>
<tr>
<td>- Engages in associate play where they interact with others in play.</td>
<td>“markers are for coloring paper and not friends! Can you show me how to color the paper?”</td>
</tr>
</tbody>
</table>

| Four year old | |
| - Desire independence and wish to do things themselves. | - Model desired behaviors, actions and phrases. |
| - Can follow simple rules. | - Praise and positive reinforcement to encourage desirable behaviors. |
| - Want to make decisions. | - Praise effort, not outcome. |
| - Experience a broader range of emotions, such as jealousy, excitement, anger and fear. | - Be consistent. |
| - Focused on winning when playing games. | - Remind children of rules when they forget. |
| - More readily shares. | - Offer limited choices (2-3) when possible to give the child a sense of responsibility and autonomy. |
| - May have an imaginary friend. | - Provide opportunities for gross motor and generally physical play. |

### School Age Children 5-12 year olds

<table>
<thead>
<tr>
<th>Behavior Expectations</th>
<th>Positive Guidance</th>
</tr>
</thead>
</table>

Section 12 - Child Guidance and Interaction 4
<table>
<thead>
<tr>
<th>Five to nine year old</th>
<th>Ten to twelve year old</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Developing skills like pouring from a pitcher and setting the table.</td>
<td>- Set clear expectations through verbal explanations and posted class rules.</td>
</tr>
<tr>
<td>- Cares a great deal about what is fair.</td>
<td>- Physically redirect by asking children to take breaks or directing them to a different area or activity when frustrated.</td>
</tr>
<tr>
<td>- Experiences emotional extremes and contradictions.</td>
<td>- Verbally redirect by restating expectations and guiding children through navigating a conflict.</td>
</tr>
<tr>
<td>- Often eager to please others. They want to make friends and receive positive responses from adults.</td>
<td>- Model desired behaviors, actions and phrases.</td>
</tr>
<tr>
<td>- Engages in cooperative play, child plays with others and has interest in the other children and shared activity.</td>
<td>- Praise and positive reinforcement to encourage desirable behaviors.</td>
</tr>
<tr>
<td>- They may experiment with lying.</td>
<td>- Praise effort, not outcome. For example: “Great job taking a break when you were frustrated“.</td>
</tr>
<tr>
<td>- Develop long attention spans and are able to handle more complicated projects and tasks.</td>
<td>- Be consistent.</td>
</tr>
<tr>
<td>- Begin to differentiate between real and imaginary around age six and may be more interested in doing “real” things.</td>
<td>- Continue to provide opportunities for gross motor and physical play.</td>
</tr>
<tr>
<td>- Major gross motor development continues through age eight.</td>
<td>- Consequences should be logical to the child's actions.</td>
</tr>
<tr>
<td>- Demonstrate intense curiosity.</td>
<td>- Provide opportunities for children to play creatively (free form block sets, dolls, costumes, and open ended art).</td>
</tr>
<tr>
<td>- Handle quick transitions and change more easily.</td>
<td>- Promote independence and responsibility by offering a wider variety of choices and providing opportunities for children to do classroom tasks or jobs wherever possible.</td>
</tr>
<tr>
<td>- Become self conscious and even self critical.</td>
<td>- Model healthy body image. Caregivers should avoid comments that criticize your own body or others, and set an example of healthy eating habits.</td>
</tr>
</tbody>
</table>

---

Section 12 - Child Guidance and Interaction
can lead to risk taking behavior and impulsiveness.
- May be filled with anxiety.
- Solidifies independence from parents and caregivers, but wants approval from adults.
- Concerned with fairness and justice.

Compliance Guidelines
- The provider may inform staff, parents, and children of the program's behavioral expectations in a variety of ways, such as making the information part of the orientation for new enrolling parents, putting it in a parent handbook, or posting it on a parent bulletin board.

Risk Level
Low

Corrective Action for 1st Instance
Warning

(3) The provider shall ensure that individuals who interact with the children guide children's behavior by using positive reinforcement, redirection, and by setting clear limits that promote children's ability to become self-disciplined.

Rationale/Explanation
Discipline is best received when it includes positive guidance, redirection, and setting clear-cut limits that foster the child's ability to become self-disciplined. In order to respond effectively when children display challenging behavior, it is beneficial for caregivers/teachers to understand typical social and emotional development and behaviors. Discipline is an ongoing process to help children develop inner control so they can manage their own behavior in a socially approved manner.

Children's ability to manage their own behaviors is supported when caregivers:
- Have a positive relationship with the children.
- Expectations should be developmentally appropriate.
- Adapt the physical indoor and outdoor learning environment to encourage positive behavior and self regulation.
- Create a predictable daily routine and schedule.
- Modify routines, activities and transitions to support children's appropriate behavior.
- Use encouragement and descriptive praise to point out appropriate behaviors.
- Show children positive alternatives.
- Set clear, direct, and simple limits.
- Model desired behaviors.
- Use planned ignoring and redirection. Certain behaviors can be ignored while at the same time the adult redirects the child to another activity.
- Individualize discipline based on the individual needs of children.

CFOC 4th ed. Standard 2.2.0.6 p.p. 73-74.
(4) The provider shall ensure that caregivers use gentle, passive restraint with children only when it is needed to protect children from injuring themselves or others, or to stop them from destroying property.

Rationale/Explanation
It should never be necessary to physically restrain a typically developing child unless his/her safety and/or that of others are at risk. When a child with special behavioral or mental health issues is enrolled who may frequently need the cautious use of restraint in the event of behavior that endangers his or her safety or the safety of others, a behavioral care plan should be developed with input from the child's primary care provider, mental health provider, parents/guardians, center director/family child care home caregiver/teacher, child care health consultant, and possibly early childhood mental health consultant in order to address underlying issues and reduce the need for physical restraint. CFOC 4th ed. Standard 2.2.0.10 p.p. 79.

The Crisis Prevention Institute offers training and certifications in nonviolent crisis intervention which includes safe restraint. Though experts agree, the only truly safe restraint is the one that never occurs. Restraint reduction is a goal for all programs that are committed to safely managing agitated behavior and dedicated to providing person centered care. Caregivers who use gentle passive restraint should be trained in:

• Recognizing the warning signs of escalating behavior.
• Verbal and nonverbal de-escalation techniques to prevent behaviors from progressing.
• Identifying triggers that cause a child to act out.
• Last-resort methods for intervening physically with as little potential for harm as possible.
• Recognizing signs of distress.
• Documenting incidents.
• Establishing and re-establishing strong and supportive relationships with students.

Compliance Guidelines
• Caregivers use positive guidance, redirection and de escalation before resorting to physically restraining a child.
• Gentle, passive restraint is only used to protect the health and safety individuals in the facility from physical injury, or damage to property.

(5) The provider shall ensure that interactions with the children do not include:
   (a) any form of corporal punishment or any action that produces physical pain or discomfort such as hitting, spanking, shaking, biting, or pinching;
   (b) restraining a child's movement by binding, tying, or any other form of restraint that exceeds gentle, passive restraint;
   (c) shouting at children;
   (d) any form of emotional abuse;
   (e) forcing or withholding food, rest, or toileting; or
(f) confining a child in a closet, locked room, or other enclosure such as a box, cupboard, or cage.

Rationale/Explanation
Child care programs must not tolerate, or in any manner condone, an act of abuse or neglect of a child. The following behaviors by an older child, caregiver/teacher, substitute or any other person employed by the facility, volunteer, or visitor should be prohibited in all child care settings:

a. The use of corporal punishment/physical abuse (punishment inflicted directly on the body), including, but not limited to
   1. Hitting, spanking (striking a child with an open hand or instrument on the buttocks or extremities with the intention of modifying behavior without causing physical injury), shaking, slapping, twisting, pulling, squeezing, or biting
   2. Demanding excessive physical exercise, excessive rest, or strenuous or bizarre postures
   3. Forcing and/or demanding physical touch from the child
   4. Compelling a child to eat or have soap, food, spices, or foreign substances in their mouth
   5. Exposing a child to extreme temperatures
b. Isolating a child in an adjacent room, hallway, closet, darkened area, play area, or any other area where the child cannot be seen or supervised
c. Binding or tying to restrict movement, such as in a car seat (except when traveling) or taping the mouth
d. Using or withholding food as a punishment or reward
e. Toilet learning/training methods that punish, demean, or humiliate a child
f. Any form of emotional abuse, including rejecting, terrorizing, extended ignoring, isolating, or corrupting a child
g. Any form of sexual abuse (Sexual abuse in the form of inappropriate touching is an act that induces or coerces children in a sexually suggestive manner or for the sexual gratification of the adult, such as sexual penetration and/or overall inappropriate touching or kissing.)
h. Abusive, profane, or sarcastic language or verbal abuse, threats, or derogatory remarks about the child or child's family
i. Any form of public or private humiliation, including threats of physical punishment (2)
j. Physical activity/outdoor time taken away as punishment Children should not see hitting, ridicule, and/or similar types of behavior among staff members. CFOC 4th ed. Standard 2.2.0.9 p.p. 78.

A child could be harmed if not restrained properly. No bonds, ties, blankets, straps, car seats, or heavy weights (such as an adult sitting on a child), or abusive words should be used. CFOC 4th ed. Standard 2.2.0.10 p.p. 79.

Modeling is an effective way of confirming that a behavior is one to be imitated. Caregivers/teachers are important in the lives of the young children in their care. They should be
educated and supported to be able to interact optimally with the children in their care. CFOC 4th ed. Standard 2.4.1.2 p.p. 87.

Time-out (also known as temporary separation) is one strategy to help children change their behavior and should be used in the context of a positive behavioral support approach which works to understand undesired behaviors and teach new skills to replace the behavior. Listed below are guidelines when using time-out:

a. Time-outs should be used for behaviors that are persistent and unacceptable, used infrequently and used only for children who are at least two years of age. Time-outs can be considered an extended ignore or a time-out from positive reinforcement;
b. The caregiver/teacher should explain how time-out works to the child BEFORE they use it the first time. The adult should be clear about the behavior that will lead to time-out;
c. When placing the child in time-out, the caregiver/teacher should stay calm;
d. While the child is in time-out, the caregiver/teacher should not talk to or look at the child (as an extended ignore). However, the adult should keep the child in sight. The child could 1) remain sitting quietly in a chair or on a pillow within the room or 2) participate in some activity that requires solitary pursuit (painting, coloring, puzzle, etc.) If the child cannot remain in the room, s/he will spend time in an alternate space, with supervision;
e. Time-outs do not need to be long. The caregiver/teacher should use the one minute of time-out for each year of the child's age (e.g., three-years-old = three minutes of time-out);
f. The caregiver/teacher 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;
g. If the child is unable to be distracted or consoled, parents/ guardians should be contacted. How to respond to failure to cooperate during time-out: Caregivers/teachers should expect resistance from children who are new to the time-out procedure. If a child has never experienced time-out, they may respond by becoming very emotional. Time-out should not turn into a power struggle with the child. If the child is refusing to stay on time-out, the caregiver/teacher should give the child an if/then statement. For example, “if you cannot take your time-out, then you cannot join story time.” If the child continues to refuse the time-out, then the child cannot join story time. Note that children should not be restrained to keep them in time-out. CFOC 4th ed. Standard 2.2.0.6 p.p. 74.

Compliance Guidelines
• Licensing staff will require that any inappropriate or abusive interactions with children be immediately stopped, if observed during an inspection.

Examples of inappropriate interactions include:
• Jerking, pulling, lifting or swinging a child by the arm(s) which can cause a partial dislocation of the elbow, also referred to as nursemaid's elbow.
• Squirting a child with water, or putting hot sauce or soap in a child's mouth.
• Placing a child in a harness or leash which is considered restraining a child's movements.
• A provider's use of profanity in the presence of a child.
• Using humiliation to discipline a child, such as putting an older child in a highchair or crib, or
Putting an older child in a younger classroom to make the child look like a "baby."
- A special treat or snack is withheld as a discipline measure.
- An awake child is forced to rest for more than 30 minutes with no other activity being provided for the child. For example, requiring an awake child to lie on a mat for more than 30 minutes with nothing else to do is considered out of compliance. However, having the child rest on a mat for more than 30 minutes may be appropriate if the child is provided with books or a similar quiet activity.
- Forcing a child to cover their head during rest or nap time.

The following are not rule violations:
- Refraining from offering dessert when a child does not finish their meal (although it is not best practice to use food as a reward for finishing other food).
- Offering treats when potty training a child.
- Swaddling a child unless it is used as a form of discipline.
- Covering a child's hand with a sock, as long as movement of the child's arm and hand is not restricted, and it is not done to humiliate or demean a child.
- Shouting to a child in an emergency situation where there is imminent danger of serious physical harm (for example, shouting to prevent a child from running into the street).

**Risk Level**
High

**Corrective Action for 1st Instance**
Citation and CMP Warning

(6) Any individual who witnesses or suspects that a child has been subjected to abuse, neglect, or exploitation shall immediately notify Child Protective Services or law enforcement as required in state law.

**Rationale/Explanation**
The facility should report any instance in which there is reasonable cause to believe that child abuse and/or neglect has occurred to the child abuse reporting hotline, department of social services, child protective services, or police as required by state and local laws. CFOC 4th ed. Standard 3.4.4.1 p.p. 132-133.

For more information about preventing abuse and neglect, refer to:
- Prevent Child Abuse Utah
- Caring for our Children 4th ed. Appendix M and N. pp. 494-499
- Prevent Child Abuse America

**Compliance Guidelines**
- If a person has reason to believe that abuse or neglect has occurred, it must be reported. If witnessed or suspected, abuse or neglect should be directly reported to the Division of Child and Family Services (DCFS) hotline at 1-855-323-3237, or to law enforcement. An individual is in violation of law and is out of compliance with this rule if they do not report, or if they only
report to an attorney, owner, director, their supervisor, or only to CCL.
• It is acceptable if an employee discusses suspected abuse with the provider before reporting
and together they determine that abuse is or is not suspected. For example, the provider may
know that a child's injury was from a fall and not due to abuse, and gives that information to
the employee. However, if abuse or neglect is suspected, reporting it to a supervisor does not
replace the requirement to report to DCFS.

**Risk Level**
High

**Corrective Action for 1st Instance**
Citation and CMP Warning
This section introduces the rules and information about preventing physical injury and other harm to children. These rules apply to both the indoor and outdoor areas of the facility including vehicles when they are accessible to the children.

To keep children safe, the provider is responsible to 1) ensure that the child care environment is free of hazards and/or that hazards are inaccessible to children, and 2) provide necessary supervision in preventing harm to children.

Refer to 50-2(27) for the definition of inaccessible and approved ways of making hazards inaccessible.

(1) The provider shall ensure that the building, outdoor area, toys, and equipment are used in a safe manner and as intended by the manufacturer to prevent injury to children.

**Rationale/Explanation**
The provider has a duty to protect everyone in their facility by complying with manufacturer safety guidelines. Manufacturer instructions contain important safety information that helps avoid injury and property damage. Additionally, not using a product according to manufacturer instructions can be used against the provider if an accident occurred and legal action was taken.

Ultimately, carefully planned environments; staffing that supports nurturing, individualized, and engaged caregiving; and well-planned, responsive care routines support active supervision in environments. CFOC 4th ed. Standard 2.2.0.1 p.p. 69.

**Compliance Guidelines**
This rule will be considered out of compliance when a child or adult is allowed to use the building, a toy, equipment, or another item in an unsafe way (for example, a child goes down the slide head first and a caregiver does not immediately address the situation, or children are near an adult who is using equipment, such as a chain saw or lawn edger, that requires safety protection).

**Risk Level**
Moderate

**Corrective Action for 1st Instance**
Citation Warning

(2) The provider shall ensure that poisonous and harmful plants are inaccessible to children.

**Rationale/Explanation**
Plants are among the most common household substances that children ingest. Determining the toxicity of every commercially available household plant is difficult. A more reasonable approach is to keep any unknown plant out of the environment that children use. All outdoor plants and their leaves, fruit, and stems should be considered potentially toxic. CFOC 4th ed. Standard 5.2.9.10 p.p. 249.

**Compliance Guidelines**
Poisonous and harmful plants must be made inaccessible to children both in the indoor play environment and in the outdoor play area.

For a list of poisonous and harmful plants, refer to the [Utah Poison Control Center](#).

**Risk Level**
Moderate

**Corrective Action for 1st Instance**
Citation Warning

(3) The provider shall ensure that sharp objects, edges, corners, or points that could cut or puncture skin are inaccessible to children.

**Rationale/Explanation**
Equipment, materials, furnishings, and play areas should be sturdy, safe, and in good repair and should meet the recommendations of the U.S. Consumer Product Safety Commission (CPSC) for control of safety hazards including sharp points or corners. CFOC 4th ed. Standards 5.3.1.1 - 5.3.1.2 p.p. 253-254.

**Compliance Guidelines**
- With active supervision, children may use woodworking tools, but sharp woodworking tools must be inaccessible when not in use.
- With active supervision, school-age children may use sewing needles, but they must be inaccessible when not in use.

Consider an object to be sharp if:
- It is has an edge or point that is made for the purpose of cutting, slicing, piercing, or puncturing another object, such as a pair of adult scissors, a knife, razor (including electric with exposed blades), staple gun, thumb tack, sewing needle (including for a sewing machine), antler, quill, etc.
- It has an edge or point that could cut, slice, pierce, or puncture because it is broken, in disrepair, or improperly installed, such as toys or other objects with jagged or sharp edges, nails or screws with protruding points, etc.
- It has a rigid edge or point that is likely to cut or puncture when coming into contact with bare skin, such as a plugged-in fan or paper shredder without a finger guard that prevents a child's fingers from reaching the blades.
• Puncture weeds and thistles that are accessible in the outdoor play area are considered sharp objects.

The following objects will not be considered sharp objects:
• Furniture edges (unless they are broken)
• Hammers and screwdrivers
• Cheese graters, apple corers, and vegetable peelers
• Tape dispenser and staple removers
• Icicles
• Scissors with blunt or round blade ends

**RISK LEVEL**
Moderate

**CORRECTIVE ACTION FOR 1ST INSTANCE**
Citation Warning

(4) The provider shall ensure that choking hazards are inaccessible to children younger than three years old.

**RATIONALE/EXPLANATION**
Choking occurs when food or other object blocks the airway making it difficult or impossible to breathe. A blocked airway can quickly lead to severe complications, including brain damage and death. According to the American Academy of Pediatrics (AAP), young children are at higher risk of choking because they tend to put objects in their mouths and because their windpipes (tracheas) are narrow (about the size of a drinking straw's diameter). A child chokes to death approximately every five days; and 75% of choking deaths occur in children under the age of 3 years, making choking a leading cause of death in infants and toddlers.

Injury and fatality from aspiration of small parts is well documented. Eliminating small parts from children's environments will greatly reduce the risk. Objects should not be small enough to fit entirely into a child's mouth. 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; any part smaller than this has a potential choking hazard. CFOC 4th ed. Standard 6.4.1.2 p.p. 303-304.

In 2010, the American Academy of Pediatrics released guidelines for choking prevention for parents and health care providers. Knowing which objects most often cause choking can reduce risk, so common choking hazards (other than food) are listed below:
• Coins
• Buttons
• Toys with small parts
• Objects that can fit entirely in a child's mouth (blocks, small balls, marbles, small stones, etc.)
• Balloons
• Small hair bows, barrettes, rubber bands, jewelry
• Art and craft supplies (pen or marker caps, macaroni, beans, beads, craft eyes, chalk, etc.)
• Small magnets, game board pieces, etc.
• Pet food

First Aid for Families (PedFACTs) (Copyright © 2012 American Academy of Pediatrics)

Compliance Guidelines
• An object is considered a choking hazard if it fits completely in a choke tube without altering its natural shape.
• A choking hazard in any room or area of the facility (including bathrooms and outdoor areas) must be inaccessible if the area is being used or can be accessed by children younger than 3 years old.

Allow the following exceptions to rule:
• Children younger than 3 years old may use materials smaller than the approved size (e.g., game pieces or art materials such as crayons, uncooked pasta, etc.) only in a carefully supervised activity. This means a caregiver is within arm’s reach of the children and providing constant, active supervision; and the caregiver does not leave until the materials are made inaccessible.
• If a crayon or other object breaks and becomes a choking hazard while in use, it will not be a rule violation if the caregiver immediately removes the hazard, or stays within arms reach and provides constant, active supervision.
• Food will not be considered a choking hazard if:
  - The food quickly melts, dissolves or crumbles in the mouth without chewing,
  - The children are eating the food at a supervised meal, or
  - For infants and toddlers, the food is cut into the appropriate size. Refer to “Section 24: Infant and Toddler Care.”
• Attached caps (such as marker and bottle caps), attached lids (such as glue stick and chapstick lids), and attached paper clips will not be considered choking hazards.
• Small items (such as uncooked pasta) that are in the unopened original packaging will not be considered choking hazards.
• Elements of nature (items that are not man made, such as rocks, shells, pine cones, acorns, sticks, etc.) and parts of protective cushioning (such as bark) that are smaller than the allowed size may be accessible to children in the outdoor area.
• Chalk will not be considered a choking hazard.
• An object smaller than ½ by ½ inch will not be considered a choking hazard.

Risk Level
Moderate

Corrective Action for 1st Instance
Citation Warning

(5) The provider shall ensure that strangulation hazards such as ropes, cords, chains, and wires attached to a structure and long enough to encircle a child's neck are inaccessible to children.
**Rationale/Explanation**
Strings and cords (such as those found on window coverings) long enough to encircle a child's neck should not be accessible to children in child care. CFOC 4th ed. Standard 3.4.6.1 p.p. 138.

The Food and Drug Administration (FDA) has alerted parents, caregivers, and health care professionals that necklaces, bracelets, and other jewelry marketed for relieving teething pain or for providing sensory stimulation should not be used. Such use could lead to strangulation, choking, serious injuries, or death. For more information, refer to the [Food and Drug Administration](https://www.fda.gov).

**Compliance Guidelines**
Examples of noncompliance include:
- Window covering cords or chains that are accessible to children (hanging within 36 inches of the floor).
- Ropes, cords, chains, or wires that are attached to structures, such as railings, fences, and decks, and are hanging within 36 inches of the floor or ground.
- Ropes, cords, chains, or wires that are longer than 12 inches and can make a loop 5 inches or greater in diameter and are attached to secure objects.

It is not out of compliance if:
- Children play with lacing cards, stringing beads, yarn, ribbon, boondoggle, scarves, string, shoelaces, jump ropes, dress-up clothing with ties, purses with straps, and hanging jewelry.
- Children are properly strapped into feeding tables or highchairs with nylon safety straps.
- Lanyards and necklaces are used.
- There are accessible loose jump ropes.
- An electrical cord is plugged in (even when the cord is longer than 12 inches).
- Cords or strings that are attached to a structure with an item designed for play such as tether ball, or mallets attached to a wall of musical instruments attached to the other end, may be any length. Caregivers must maintain active supervision at all times.

---

**Risk Level**

Section 13 - Child Safety and Injury Prevention
The provider shall ensure that tripping hazards such as unsecured flooring, rugs with curled edges, or cords in walkways are inaccessible to children.

Rationale/Explanation
Inside and outside stairs, ramps, porches, and other walkways to the structure should be constructed for safe use as required by the local building code and should be kept in sound condition, well-lighted, and in good repair. Prevention of slipping and tripping hazards is key to preventing injuries from falls. CFOC 4th ed. Standard 5.1.6.2 p.p. 223.

Compliance Guidelines
• Compliance will be assessed in all areas used by children.
• Tripping hazards include:
  - Defective flooring with uneven edges coming up more than 1/4 inch from the floor level.
  - Rugs with curled edges of more than 1/4 inch above the rug level.
  - Electrical and other cords that are in or across indoor and outdoor walkways.

Risk Level
Moderate
Corrective Action for 1st Instance
Citation Warning

The provider shall ensure that empty plastic bags large enough for a child's head to fit inside, latex gloves, and balloons are inaccessible to children younger than five years old.

Rationale/Explanation
Plastic bags, whether intended for storage, trash, diaper disposal, or any other purpose, should be stored out of reach of children. Plastic bags have been recognized for many years as a cause of suffocation. Warnings regarding this risk are printed on diaper-pail bags, dry-cleaning bags, and so forth. The U.S. Consumer Product Safety Commission (CPSC) has received average annual reports of twenty-five deaths per year to children due to suffocation from plastic bags. Nearly 90% of the reported deaths were to children under the age of one. CFOC 4th ed. Standard 5.5.0.7 p.p. 274.

Compliance Guidelines
• This rule applies to:
  - Any empty plastic bag that is 9 inches in diameter or bigger (including gallon-size storage bags).
  - Plastic bags in a roll that are in accessible drawers, cupboards, containers, open boxes, or dispensers.
  - Balloons and punch balls whether or not inflated.
• This rule does not apply to:
  - Bags smaller than 9 inches in diameter.
  - Plastic trash can liners inside of a trash can.
  - Plastic grocery bags being used in activities (such as making kites) with constant, active supervision.
  - A plastic bag that is tied in a knot.
  - Plastic bags, latex gloves, or balloons in a sealed box that has not yet been opened.
  - Latex gloves or empty bags on a changing table, if they are only within reach of the child on the changing table.
  - Multiple-use rubber gloves.
  - Mylar balloons.
  - Balloons encased in a non latex material (such as nylon or tulle), but the rule does apply to a balloon encased in a second balloon.

Risk Level
Moderate

Corrective Action for 1st Instance
Citation Warning

(8) The provider shall ensure that standing water that measures two inches or deeper and five by five inches or greater in diameter is inaccessible to children

Rationale/Explanation
Small children can drown within thirty seconds, in as little as two inches of liquid. Drowning is the second leading cause of unintentional injury-related death for children ages one to fourteen. In 2006, approximately 1,100 children under the age of twenty in the U.S. died from drowning.

Thirty children under five years of age died from drowning in buckets, pails, and containers from 2003-2005. Of all buckets, the five-gallon size presents the greatest hazard to young children because of its tall straight sides and its weight with even just a small amount of liquid. It is nearly impossible for top-heavy (their heads) infants and toddlers to free themselves when they fall into a five-gallon bucket head first. CFOC 4th ed. Standard 2.2.0.4 p.p. 71-72.

Compliance Guidelines
The following is a list of common places standing water may be found:
• Buckets (including mop buckets) and other containers
• Coolers and ice chests
• Water features such as fountains, birdbaths, etc.
• Garbage cans or other similar containers
• Wheelbarrows
• Bathtubs

The following is not considered to be standing water:
• Water being used as part of a supervised project such as painting on the sidewalk with water
• Water in a water table
• Temporary puddles on the ground caused by weather or sprinklers
• Animal water bowls or enclosed water dispensers, unless the water is served in a bucket
• Toilets
• Fish bowls, fish tanks, and aquariums (except for fish ponds and similar water features)

**Risk Level**

High

**Corrective Action for 1st Instance**

Citation and CMP Warning

(9) The provider shall ensure that toxic or hazardous chemicals such as cleaners, insecticides, lawn products, and flammable, corrosive, and reactive materials are:

(a) inaccessible to children;
(b) used according to manufacturer instructions;
(c) stored in containers labeled with the contents of the container; and
(d) disposed of properly.

**Rationale/Explanation**

**Inaccessible**

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 commonly involved in poison exposures of children are cosmetics and personal care products, cleaning substances, and medications. CFOC 4th ed. Standard 5.2.9.1 p.p. 243.

Flammable materials such as chemicals and cleaners account for the majority of burns to the head and face of children. These materials are also involved in unintentional ingestion by children. CFOC 4th ed. Standard 5.5.0.5 p.p. 274.

**Used According to Instructions**

Children must be protected from exposure to pesticides. To prevent contamination and poisoning, child care staff must be sure that these chemicals are applied by individuals who are licensed and certified to do so. Exposure to pesticides has been linked to learning and developmental disorders. Direct observation of pesticide application by child care staff is essential to guide the pest management professional away from surfaces that children can touch or mouth and to monitor for drifting of pesticides into these areas. CFOC 4th ed. Standard 5.2.8.1 p.p. 242.

**Stored in Labeled Containers**

Staff should always read the label prior to use to determine safety in use. CFOC 4th ed. Standard 5.2.9.3. pp. 244. [www.poison.org](http://www.poison.org).

**Disposed of Properly**
Infectious and toxic wastes should be stored separately from other wastes, and should be disposed of in a manner approved by the regulatory health authority. This practice provides for safe storage and disposal of infectious and toxic wastes. CFOC 4th ed. Standard 5.2.7.7 p.p. 241

**Compliance Guidelines**

- Toiletries (products used to clean and/or groom one’s body, including hair dye) are not required to be inaccessible. This includes hand sanitizers, even those containing alcohol.
- Aerosol cans containing toiletries and air fresheners will not be assessed as toxic or hazardous chemicals. All other aerosol cans are considered flammable and must be inaccessible.
- Nail polish remover, and contact lens cleaner solutions will be considered chemicals and have to be made inaccessible to children.
- Cleaners such as dish soap and laundry detergent, that are not intended to be used on one’s body, must be inaccessible to children. However, dish soap and borax may be used for educational purposes only in a carefully supervised activity. This means a caregiver is within arm’s reach of the children and providing constant, active supervision; and the caregiver does not leave until the materials are made inaccessible.
- Rubbing alcohol is assessed as a medication. Refer to section 17 for medication compliance guidelines.
- A cleaning bucket that contains a chemical and is in use does not need to be labeled with its contents.
- A bucket does not need to be labeled if used to carry or store labeled containers of chemicals.
- Disinfecting wipes or another sanitizing solution on a changing table will not be considered out of compliance as long as the changing table meets the definition of inaccessible.
- Gasoline and other similar products enclosed in a vehicle or equipment, such as a lawnmower, are not considered accessible.
- Paint and other substances in a sealed can are considered inaccessible if the lid is securely attached and can only be opened with a tool.
- A cleaner that is attached to the inside of a toilet bowl is not considered accessible.
- Batteries are corrosive. Loose batteries or batteries not currently in a battery powered device, must be inaccessible to children.
- The provider is not out of compliance with the rule if a product labeled by the manufacturer as non-toxic or non-hazardous is accessible.

**Risk Level**

Moderate

**Corrective Action for 1st Instance**

Citation Warning

(10) **The provider shall ensure that the following items are inaccessible to children:**

(a) matches or cigarette lighters;
(b) open flames;
(c) hot wax or other hot substances; and
(d) when in use, portable space heaters, wood burning stoves, and fireplaces.
**Rationale/Explanation**

The U.S. Consumer Product Safety Commission (CPSC) estimates that 150 deaths occur each year from fires started by children playing with lighters. Children under five-years old account for most of these fatalities. A child playing with candles or near candles is one of the biggest contributors to candle fires. Matches have also been the source of some fire-related deaths. Children may hide in a closet or under a bed when faced with fire, leading to fatalities. CFOC 4th ed. Standard 5.5.0.6 p.p. 274.

The most common burn suffered by young children is scalding from hot liquids tipped over in the kitchen. The skin of young children is much thinner than that of adults and can burn at temperatures that adults find comfortable. In a recent study, 90.4% of scald injuries to children under age five were related to hot cooking or drinking liquids. CFOC 4th ed. Standard 4.5.0.9 p.p. 192.

Portable electric space heaters are a common cause of fires and burns resulting from very hot heating elements being too close to flammable objects and people. Fireplaces provide access to surfaces hot enough to cause burns. Children should be kept away from fire because their clothing can easily ignite. Children should be kept away from a hot surface because they can be burned simply by touching it. A mechanical barrier separating the child from the source of heat can reduce the likelihood of burns, CFOC 4th ed. Standards 5.2.1.11- 5.2.1.13 p.p. 228-230.

**Compliance Guidelines**

- Candles on a birthday cake or cupcake may be used as long as an adult is in constant arm's reach of the lit candles until the candles are blown out.
- A fireplace pilot light will not be considered a violation.
- A space heater is any heater that can be moved and is not permanently installed into the wall. This includes convection heaters, infrared heaters, patio heaters, and space heaters that are manufactured to look like fireplaces. This rule applies to all types of fireplaces including electric, gas, and infrared fireplaces.
- Space heaters, wood burning stoves, and fireplaces of any type are allowed when:
  - They are not used while children are in care.
  - They are inaccessible to children if used while children are in care. (A child safety gate may make a piece of heating equipment inaccessible if the gate is attached to the wall on both sides and is at least 36 inches away from all sides of the heating equipment.)
  - The provider has documentation from the manufacturer that a specific piece of heating equipment is safe for children to touch, and therefore may be accessible and used while children are in care.

If accessible to children, items considered out of compliance include:
- A cigarette lighter, whether or not the lighter contains fluid.
- Plug-in warmers that contain melted wax or hot oil.
- Hot glue guns, irons, and hair styling irons that are plugged in.
- Hot liquids, foods, and substances in an appliance (such as a crock pot or coffee pot).
- Electrical cords from an appliance containing a hot substance that children could pull down.
Risk Level
High
Corrective Action for 1st Instance
Citation and CMP Warning when:
Open flames are accessible to children.

Risk Level
Moderate
Corrective Action for 1st Instance
Citation Warning otherwise

(11) The provider shall ensure that the following items are inaccessible to children:
 (a) live electrical wires; and
 (b) for children younger than five years old, electrical outlets and surge protectors without protective caps or safety devices when not in use.

Rationale/Explanation
Tamper-resistant electrical outlets or securely attached safety covers prevent children from placing fingers or sticking objects into exposed electrical outlets and reduce the risk of electrical shock, electrical burns, and potential fires. GFCIs provide protection from electrocution when an electric outlet or electric product may come into contact with water. Approximately 2,400 children are injured annually by inserting objects into the slots of electrical outlets. The majority of these injuries involve children under the age of six. CFOC 4th ed. Standard 5.2.4.2 p.p. 233.

Compliance Guidelines
• Exposed electrical wires (the metal is exposed) will be considered live. They will be treated as if electrical current is running through them and will not be tested to determine compliance.
• In areas used by children younger than 5 years old, electrical outlets and surge protectors must be inaccessible or have protective caps or safety devices when not in use. This includes areas within 36 inches from:
  - Any sleeping surface used by infants, including in rooms that are only used for napping.
  - Any surface in a bathroom where a child could climb or stand, such as a bathtub, toilet or counter.

Refer to the following information about outlets and surge protectors that must be inaccessible to children younger than 5 years old.
• GFCI Protected outlets have “Test” and “Reset” buttons built into the outlets.
• A grounded outlet is one that has holes for three prongs and must be inaccessible or have a protective cover unless it is tamper resistant. However, the bottom grounding hole is not required to be covered or protected.
• All unused plugs in surge protectors must be covered. Some surge protectors pose a fire hazard if covered with individual safety caps. There are covers that encase the entire surge protector that may be safer to use.
Acceptable ways to protect or cover outlets (receptacles) include:
• Install tamper-resistant receptacles. They appear to have the slots filled in and are labeled “TR” between the two slots or with the words “tamper-resistant.”
• Use individual outlet caps to cover all openings in the outlet or surge protector.
• Install an electrical outlet cover (or safe plate) that sits on top of the existing outlet.
• Replace existing outlet covers with safe plate slide covers that have spring-loaded shutters that cover the outlet openings.
• Cover receptacle openings by using an item, such as a doorbell box or deodorizer, that plugs into one plug and covers the entire outlet.

**Risk Level**
High

**Corrective Action for 1st Instance**
Citation and CMP Warning when:
An exposed live electrical wire is accessible.

**Risk Level**
Moderate

**Corrective Action for 1st Instance**
Citation Warning when:
An electrical outlet or surge protector is without a protective cap or safety device when not in use and is accessible to children younger than 5 years old.

(12) **Unless used and stored in compliance with the Utah Concealed Weapons Act or as otherwise allowed by law, the provider shall ensure that firearms such as guns, muzzleloaders, rifles, shotguns, hand guns, pistols, and automatic guns are:**
(a) locked in a cabinet or area using a key, combination lock, or fingerprint lock; and
(b) stored unloaded and separate from ammunition.

**Rationale/Explanation**
Approximately 20,000 children are taken to emergency departments for firearm-related injuries every year and the majority of these injuries are accidental. Younger children are more likely to be unintentionally injured, and the majority of these accidental shootings occur in homes. It is critical that firearms be properly locked. “Pediatric Firearm-Related Injuries in the United States” (Parikh K, et al. Hosp Pediatr. May 23, 2017).

Visit the [Utah Department of Public Safety](https://www.utah.gov/dps) for answers to frequently asked concealed firearm permit questions.

**Compliance Guidelines**
• Guns that are dismantled and do not contain a trigger mechanism are not considered a firearm.
• Firearms must be stored unloaded. Ammunition may be stored in the same area as the
firearm as long as the area is locked according to rule.
• When a gun that cannot be fired is used as decoration, the provider can apply for a variance that includes documentation from a gunsmith that the specific gun cannot be fired.
• Firearms must be locked according to rule. Using an alternate type of lock, such as a trigger lock or a lock that is controlled by swiping an app on a cell phone, is out of compliance.
• CCL staff will observe where each firearm on the property is stored, including firearms stored in outbuildings and vehicles.
• If a firearm is stored in a vehicle that is not used to transport children, the vehicle must be locked with a key or keypad.
• If a firearm is stored in a vehicle that is used to transport children, the firearm must be locked with a key, combination lock, or fingerprint lock within the vehicle.

**Risk Level**
Extreme

**Corrective Action for 1st Instance**
Citation and CMP when:
A firearm is accessible to children.

**Risk Level**
High

**Corrective Action for 1st Instance**
Citation and CMP Warning otherwise.
A firearm is inaccessible but not locked with a key, combination lock, or fingerprint lock.

(13) The provider shall ensure that weapons such as paintball guns, BB guns, airsoft guns, sling shots, arrows, and mace are inaccessible to children.

**Rationale/Explanation**
The potential for injury to and death of young children due to firearms is apparent. These items should not be accessible to children in a facility CFOC 4th ed. Standard 9.2.3.16 p.p. 392.

**Compliance Guidelines**
• A weapon is defined as an item for which the intended use can cause harm or death to people or animals.
• CCL staff will observe where each weapon on the property is stored, including weapons stored in outbuildings and vehicles.
• Bows (if arrows are inaccessible) can be accessible.
• Crossbows (with or without arrows) must be inaccessible.
• Arrows must be inaccessible.

**Risk Level**
High

**Corrective Action for 1st Instance**
Citation and CMP Warning
(14) The provider shall ensure that alcohol, illegal substances, and sexually explicit material are inaccessible, and not used on the premises, during offsite activities, or in facility vehicles any time a child is in care.

**Rationale/Explanation**
Alcohol, illegal substances, and sexually explicit material must be inaccessible to prevent potential ingestion or exposure. The age, defenselessness, and dependence upon the judgment of caregivers/teachers of the children under care make this prohibition an absolute requirement. CFOC 4th ed. Standard 3.4.1.1 p.p. 127.

**Compliance Guidelines**
• In addition to making sexually explicit materials inaccessible to children, the facility must be free of any depiction of nudity in a lascivious manner through pictures, posters, media, etc., while children are in care.
• The facility must be free of any illegal substances. Illegal substances are any items that by law are not allowed to be produced, consumed, sold, or present in the facility.
• Alcohol in a container that can only be opened with a tool (such as a corkscrew) is considered inaccessible.
• Open bottles of alcohol, and alcohol or illegal substances that are being served or consumed are considered in use and are prohibited when a child is in care.

**Risk Level**
High

**Corrective Action for 1st Instance**
Citation and CMP Warning

(15) The provider shall ensure that an outdoor source of drinking water, such as individually labeled water bottles, a pitcher of water and individual cups, or a working water fountain is available to each child when the outside temperature is 75 degrees or higher.

**Rationale/Explanation**
Clean, sanitary drinking water should be readily available, in indoor and outdoor areas, throughout the day. When children are thirsty between meals and snacks, water is the best choice. Drinking water helps maintain a child’s hydration and overall health. CFOC 4th ed. Standard 4.2.0.6 p.p. 167.

**Compliance Guidelines**
• The outdoor temperature can be measured by any available electronic means including a cell phone.
• Drinking water may come from a hose as long as the hose is attached to a source of culinary water (the same water that is used inside), and not a secondary water source (such as water used to irrigate or water gardens and lawns).
• Water must be accessible to the children in their play area. If a drinking fountain is behind a closed gate, it is not considered available and is a rule violation.

**Risk Level**
High

**Corrective Action for 1st Instance**
Citation and CMP Warning when:
Children do not have an outdoor source of drinking water and the temperature is 90 degrees or higher.

**Risk Level**
Moderate

**Corrective Action for 1st Instance**
Citation Warning otherwise.

(16) **The provider shall ensure that areas accessible to children are free of heavy or unstable objects that children could pull down on themselves, such as furniture, unsecured televisions, and standing ladders.**

**Rationale/Explanation**
Children have suffered serious injuries and death due to unstable heavy equipment falling on them. The Consumer Product Safety Commission estimates that:
• Every 30 minutes a child in the U.S. is injured as a result of a TV or furniture tip-over incident.
• Two-thirds of TV and furniture tip-over fatalities involve toddlers.
• On average, one child dies every two weeks from being crushed by a television set.

CPSC recommends the following to help prevent tip-over accidents:
• Anchor furniture (including entertainment units, TV stands, bookcases, shelving, and bureaus) to the floor or wall using appropriate hardware, such as brackets, screws, or toggle bolts.
• Place televisions on low, sturdy furniture or a base manufactured for that purpose.
• Place televisions on other furniture only if the furniture is anchored to the wall or floor, the TV is pushed as far back on the furniture as possible, and the TV is anchored to the wall or the anchored furniture.
• Keep remote controls, toys, and other items that might attract children off TV stands or furniture.
• Keep TV and/or cable cords out of reach of children.
• Make sure freestanding kitchen ranges and stoves are installed with anti-tip brackets.
• Never leave children alone in rooms where these safety tips have not been followed.

For more information, refer to:
• Anchor It
• Anchor for Safety: TV and Furniture Tip-Over-Related Deaths and Injuries Not Slowing Down

**Compliance Guidelines**
• Heavy furniture or other objects that are higher than 3 feet must be stable, secured, or anchored. This includes:
  - Freestanding kitchen ranges and stoves, entertainment units, TV stands, bookcases, shelving, and bureaus that are higher than 3 feet.
  - Vehicles on jack stands or blocks, piles of wood, bales of straw, stacked cinder blocks or other solid objects that are stacked.
• This rule is out of compliance when there is furniture or a heavy object that is noticeably unstable.
  - Unstable furniture means that the furniture is compromised in some way (e.g. missing or loose legs, leaning, etc.). A dresser with more than one fully open drawer will be considered unstable.
• If the stability of furniture or a heavy object is in question and cannot be verified solely through observation, the provider must be able to demonstrate that the object is stable. Otherwise, it will be considered unstable and a rule violation.
• The rule is out of compliance if there is a heavy object (such as a TV) on unstable furniture of any height.
• Only screens that are larger than 19 inches and accessible to children will be assessed.
  - Accessible means that the screen and/or attached cords are lower than 36 inches.
  - If necessary to determine the size of the screen, measure the screen diagonally from corner to corner on the inside of the frame. For more information, visit: www.wikihow.com/Measure-a-TV.
  - Even if the equipment screen is inaccessible, if the equipment cords are accessible so children could pull the screen down, the screen must be anchored.
• If the screen is larger than 19 inches and accessible, it must be securely anchored, mounted, or tied to a stable structure to be in compliance with rule. A television that is built into a stable cabinet or similar piece of furniture is considered anchored.
• A 19-inch or smaller screen or TV is not required to be anchored.
• A laptop screen is not required to be anchored.
• Any accessible stepstool or ladder that is taller than 5 feet and is leaning against a structure (such as a wall, shed, or tree) is considered unstable.
• Ladders permanently attached to a structure, stepstools and ladders measuring 5 feet or less, “Inverted V” ladders standing in an open position, and ladders lying down are not out of compliance.

**Risk Level**
Moderate

**Corrective Action for 1st Instance**
Citation Warning

(17) The provider shall ensure that hot water accessible to children does not exceed 120 degrees Fahrenheit.

**Rationale/Explanation**
Tap water burns are a common source of scald injuries in young children. Children under six years of age are the most frequent victims of non-fatal burns. Water heated to temperatures greater than 120°F takes less than thirty seconds to burn the skin. If the water is heated to 120°F it takes two minutes to burn the skin. That extra two minutes could provide enough time to remove the child from the hot water source and avoid a burn. CFOC 4th ed. Standard 5.2.1.14 p.p. 230.

**Compliance Guidelines**
- Water will be assessed at the sink used by children.
- Hot water will be measured by holding a thermometer in the running water until the temperature stops rising.
- In an effort to conserve water, there is no need to continue measuring once the temperature reaches 128 degrees Fahrenheit.
- Water temperature will be measured at each portable sink and each sink with a mixing valve that is used by children.
- If a hot water tank indicates the water temperature on a digital gauge, this measurement will be used as the assessment. In this case, there is no need to assess the water temperature at a handwashing sink connected to the water heater.
- Water faucets with motion detector shut-offs do not ensure compliance with this rule.
- Due to the variable accuracy of hot water thermometers, this rule is not considered out of compliance unless the temperature measures 123 degrees Fahrenheit or hotter.

**Risk Level**
Moderate

**Corrective Action for 1st Instance**
Citation Warning when:
The water temperature is 128 degree Fahrenheit or higher.

**Risk Level**
Low

**Corrective Action for 1st Instance**
Warning when:
The water temperature is between 123 and 127.9 degrees Fahrenheit.

(18) The provider shall ensure that highchairs that are used by children have T-shaped safety straps or safety devices that are used when a child is in the chair.

**Rationale/Explanation**
High chairs, if used, should have a wide base and a securely locking tray, along with a crotch bar/guard to prevent a child from slipping down and becoming entrapped between the tray and the seat. High chairs should also be equipped with a safety strap to prevent a child from climbing out of the chair. The safety strap should be fastened with every use. CFOC 4th ed. Standard 5.3.1.8. pp. 258.

**Compliance Guidelines**
• Booster seats are considered highchairs.
• If the chair is on or low to the floor so the child's feet touch the ground while sitting in the chair, a T-shaped strap or device is not required.
• Safety straps must be used in addition to a passive crotch restraint.

**Risk Level**
High

**Corrective Action for 1st Instance**
Citation and CMP Warning when:
The highchair does not have a T-shaped safety strap or device and is used by infants or toddlers.

**Risk Level**
Moderate

**Corrective Action for 1st Instance**
Citation Warning when:
The highchair does not have a T-shaped safety strap or device and is used by older children.

(19) The provider shall ensure that infant walkers with wheels are inaccessible to children.

**Rationale/Explanation**
Infant walkers are dangerous because they move children around too fast and to hazardous areas, such as stairs. The upright position also can cause children in walkers to “tip over” or can bring children close to objects that they can pull down onto themselves. In addition, walkers can run over or run into others, causing pain or injury. Many injuries, some fatal, have been associated with infant walkers. CFOC 4th ed. Standard 5.3.1.10 p.p. 259.

**Compliance Guidelines**
• A walker is a piece of equipment that is designed for a child to sit in and use their legs to move from one place to another. A device that has a seat that rotates, but does not have wheels that move the child around the room is not considered an infant walker.
• The rule is not out of compliance when a piece of adaptive equipment is used by a child with a disability.
• A push toy with wheels is allowed and is not considered an infant walker.
Rationale/Explanation
Scientific evidence has linked respiratory health risks to secondhand smoke. No children, especially those with respiratory problems, should be exposed to additional risk from the air they breathe. Infants and young children exposed to secondhand smoke are at risk of severe asthma; developing bronchitis, pneumonia, and middle ear infections when they experience common respiratory infections; and Sudden Infant Death Syndrome (SIDS) CFOC 4th ed. Standard 3.4.1.1 p.p. 127.

This rule is in accordance with the Utah Indoor Clean Air Act.

Compliance Guidelines
Tobacco and similar products such as the following must be inaccessible and not used on the premises, in vehicles, or in the presence of any child in care:
• Ashtrays with cigarettes and cigarette butts
• Chewing tobacco
• Cigars
• Cigarettes and cigarette butts
• E-cigarettes and E-liquid (E-juice)
• Pipes
• Vaporizers (not to be mistaken for a humidifier or steam vaporizer)

**Risk Level**
High

**Corrective Action for 1st Instance**
Citation and CMP Warning when:
Tobacco or a similar product is used any place indoors, in a vehicle, or within 25 feet of the entrance or exit of the building, a window, the outdoor play area, or a child.

**Risk Level**
Moderate

**Corrective Action for 1st Instance**
Citation Warning when:
Tobacco or a similar product is accessible to any child in care.
This section addresses the rules and guidance on preparing for and responding to an emergency. No one expects an emergency – yet emergencies can strike anyone, anytime, and anywhere. The best preparedness is planning how to respond to an emergency before it happens. Few people can think clearly and logically in a crisis, so it is important to prepare in advance when there is time to be thorough.

(1) The provider shall have an emergency preparedness, response, and recovery plan that:
   (a) includes procedures for evacuation, relocation, shelter in place, lockdown, communication with and reunification of families, and continuity of operations;
   (b) includes procedures for accommodations for infants and toddlers, children with disabilities, and children with chronic medical conditions; and
   (c) is followed if an emergency happens, unless otherwise instructed by emergency personnel.

Rationale/Explanation
Facilities should consider how to prepare for and respond to emergency or natural disaster situations and develop written plans accordingly. All programs should have procedures in place to address natural disasters that are relevant to their location (such as earthquakes, tornados, tsunamis or flash floods, storms, and volcanoes) and all hazards/disasters that could occur in any location including acts of violence, bioterrorism/terrorism, exposure to hazardous agents, facility damage, fire, missing child, power outage, and other situations that may require evacuation, lock-down, or shelter-in-place. Facilities should develop and implement a written plan that describes the practices and procedures they use to prepare for and respond to emergency or disaster situations. CFOC 4th ed. Standard 9.2.4.3 p.p. 394-395.

For guidance and resources, visit the Child Care Licensing: Emergency and Disaster Preparedness page.

Compliance Guidelines
• An emergency preparedness, response and recovery plan sample document is available on the CCL website, under Forms and Documents, as technical assistance.
• The provider must complete their emergency preparedness, response and recovery plan before the Pre-License Inspection.
• If the provider’s policies, procedures, or services change, the emergency preparedness, response and recovery plan must be updated.
• The document may be kept and made available either as a hardcopy or electronically.
• The provider must, in the event of an emergency, have the children’s emergency contact information available to them.
(2) The provider shall post the facility's street address and emergency numbers, including at least fire, police, and poison control, near the telephone in the home or in an area clearly visible to anyone needing the information.

**Rationale/Explanation**

In an easily available space that parents/guardians are made aware of and able to access, facilities should make available the phone numbers and instructions for contacting the fire department, police, emergency medical services, physicians, dentists, rescue and ambulance services, and the poison center, child abuse reporting hotline; the address of the facility; and directions to the facility from major routes north, south, east, and west (this information should be conspicuously posted adjacent to the telephone). CFOC 4th ed. Standard 9.4.1.6 p.p. 410-411.

**Compliance Guidelines**

- Posting 911 meets the requirement of posting emergency numbers for fire, and police, but not the requirement for posting the poison control number and the facility's street address.
- If a portable or cell phone is used in the facility, emergency numbers must be posted in plain view so that anyone needing the information can easily find it. Emergency numbers can be posted either on the phone, on or near the base, or in a conspicuous place. They cannot be posted behind a closet or cupboard door.

**Risk Level**

High

**Corrective Action for 1st Instance**

Citation and CMP Warning when:

- Failure to post required information resulted in emergency personnel not being contacted in an emergency or being unable to respond in a timely manner.

**Risk Level**

Moderate

**Corrective Action for 1st Instance**

Citation Warning when:

- The required emergency information is not posted near a telephone or in a place clearly visible to anyone who may need the information.

**Risk Level**

Low

**Corrective Action for 1st Instance**

Warning when:
Some but not all of the required emergency information is posted.

(3) The provider shall keep first aid supplies in the facility, including at least antiseptic, bandages, and tweezers.

Rationale/Explanation
The facility should maintain first aid and emergency supplies in each location where children are cared for CFOC 4th ed. Standard 5.6.0.1 p.p. 274-275.

Compliance Guidelines
• The required first aid supplies must be in a location that is easily available and known to those who may need to use the supplies.
• The provider may keep either a topical antiseptic, such as alcohol wipes, or a topical antibacterial, such as Neosporin, available for use as needed.

Risk Level
Low
Corrective Action for 1st Instance
Warning

(4) The provider shall conduct fire evacuation drills every six months and make sure drills include a complete exit of each child, staff, and volunteers from the building.

Rationale/Explanation
Regular emergency and evacuation drills/exercises constitute an important safety practice in areas where these natural or human generated disasters might occur. The routine practice of such drills fosters a calm, competent response to a natural or human generated disaster when it occurs. The extensive turnover of both staff and children, in addition to the changing developmental abilities of the children to participate in evacuation procedures in child care, necessitates frequent practice of the exercises. CFOC 4th ed. Standard 9.2.4.5 p.p. 399-400.

Compliance Guidelines
• Conducting fire drills quarterly means that an evacuation drill is conducted 2 times a year, at least once in each 6 month period of the licensing or calendar year.
• A fire evacuation drill needs to be conducted some time during the 6 month period, but does not need to be held exactly 6 months apart.
• An evacuation due to an actual fire counts as one of the fire drills as long as it is documented as required by rule.

Risk Level
Moderate
Corrective Action for 1st Instance
Citation Warning
(5) The provider shall conduct drills for disasters other than fires at least once every 12 months.

**Rationale/Explanation**
The only way to prepare for disasters is to consider various worst case or unique scenarios, and to develop contingency plans. By brainstorming and thinking through a variety of “what if...” situations and developing records, protocols/ procedures, and checklists, facilities will be better able to respond to an unusual emergency or disaster situation. CFOC 4th ed. Standard 9.2.4.3. p.p. 395-397.

**Compliance Guidelines**
- An evacuation or a lock-down due to an actual emergency situation counts as one of the disaster drills as long as it is documented as required by rule.
- Disasters other than fires include earthquakes, floods, prolonged power or water outage, tornados, chemical spills, an active shooter, etc.
- The provider may hold a separate fire and disaster drill on the same day, but they may not hold one drill and count it as both a fire drill and a disaster drill.
- A sample form is available under [Forms and Documents](#), titled: Fire & Disaster Drill Log, as technical assistance.
- Conducting disaster drills at least once every six months means that an evacuation drill is conducted 2 times a year, at least once in each six month period of the licensing or calendar year.
- A disaster drill needs to be conducted some time during the six month period, but does not need to be held exactly six months apart.

**Risk Level**
Moderate

**Corrective Action for 1st Instance**
Citation Warning

(6) The provider shall vary the days and times on which fire and other disaster drills are held.

**Rationale/Explanation**
Evacuation drills/exercises should be practiced at various times of the day, including nap time, during varied activities and from all exits. Children should be accounted for during the practice. CFOC 4th ed. Standard 9.2.4.5 p.p. 399-400.

**Compliance Guidelines**
Drills must be conducted on at least two different days of the week and two different times of the day.

**Risk Level**
Low

**Corrective Action for 1st Instance**
Warning
(7) The provider shall:
   (a) give parents a written report on the day of occurrence of each incident, accident, or injury involving their child;
   (b) ensure the report has the signatures of the caregivers involved, the provider, and the individual picking up the child; and
   (c) if school-age children sign themselves out of the facility, send a copy of the report to the parent on the day following the occurrence.

Rationale/Explanation
Injury patterns and child abuse and neglect can be discerned from such records and can be used to prevent future problems. Known data on typical injuries (scanning for hazards, providing direct supervision, etc.) can also how to prevent them. A report form is also necessary for providing information to the child's parents/guardians and primary care provider and other appropriate health or state agencies. CFOC 4th ed. Standard 9.4.1.9 p.p. 412-413.

Compliance Guidelines
Written incident reports are not required if the incident occurred before a child was signed in or after a child was signed out of the program.

The following are examples of incidents that must be documented and reported to parents if they occur while a child is in care:
• Any injury that requires first aid or medical attention
• A bite that breaks the skin and/or a child bites or is bitten frequently
• Falls, burns, broken limbs, tooth loss, other injury
• Blows to the head
• A reportable infectious disease (Refer to: health.utah.gov/epi/reporting/Rpt_Disease_List.pdf.)
• Recurring aggressive behavior or aggressive behavior that results in injury (For example, if children fight and one needs medical treatment, a report should be completed for each child.)
• Sudden and/or unusual behavior that is not typical for the child
• A child is neglected, abused, sexually assaulted, or inappropriately touched (also report to Child Protective Services).
• A caregiver forgets to pick up a child from school or other activity
• Ingestion of non-food substances
• A lost or missing child, and/or a child leaving the premises without a caregiver
• A motor vehicle accident when a child was being transported
• Death

When obtaining the signature of the parent or a person who picks up the child, the following guidelines apply:
• Occasionally, the provider may not immediately see the parent to obtain their signature. For example, the parent may pick their child up from school rather than from the facility, or due to a serious injury, the parent would immediately take their child for medical treatment. In these cases, the provider has 5 working days to obtain the required signature.
• If the person picking up a child refuses to sign or accept the incident report, the rule will not be found out of compliance if the provider can demonstrate that they have an effective process in place to get same-day signatures on reports and have made a good-faith effort to follow that process.
• If the parent refuses to sign the report or does not bring the child back for care, the provider may write on the report "parent refused to sign" and/or “child is no longer enrolled.”
• Provider may provide Incident and Accident Report Forms to parents or guardians in a digital format, without a signature of receipt, if the provider has received written permission from the parent or guardian to use this method of communication. This written permission must be kept on sight for review by the department.

Risk Level
Moderate
Corrective Action for 1st Instance
Citation Warning

(8) If a child is injured and the injury appears serious but not life-threatening, the provider shall contact the child's parent immediately.

Rationale/Explanation
It is important that parents are informed of any serious injury to their child so that they can make the necessary decisions about the care and medical treatment that their child receives.

Compliance Guidelines
• The provider must first try the most immediate means of contacting the parent.
• The provider may use the parent's preferred means of electronic contact, such as text, email, or instant messaging.
• The provider must contact the parents immediately after the child's critical needs are met and the other children are in a situation where their safety is not jeopardized.

Risk Level
High
Corrective Action for 1st Instance
Citation and CMP Warning when:
• A parent was not notified of a serious injury.

Risk Level
Moderate
Corrective Action for 1st Instance
Citation Warning when:
A parent was notified, but not immediately after a serious injury to their child.

(9) If a life-threatening injury to a child, or an injury that poses a threat of the loss of vision, hearing, or a limb happens, the provider shall:
(a) call emergency personnel immediately;
(b) contact the parent after emergency personnel are called; and
(c) if the parent cannot be reached, try to contact the child's emergency contact individual.

**Rationale/Explanation**
Call Emergency Medical Services (EMS) immediately if:
- You believe the child's life is at risk or there is a risk of permanent injury.
- The child is acting strangely, much less alert, or much more withdrawn than usual.
- The child has difficulty breathing, is having an asthma exacerbation, or is unable to speak.
- The child's skin or lips look blue, purple, or gray.
- The child has rhythmic jerking of arms and legs and a loss of consciousness (seizure).
- The child is unconscious.
- The child is less and less responsive.
- The child has any of the following after a head injury: decrease in level of alertness, confusion, headache, vomiting, irritability, or difficulty walking.
- The child has increasing or severe pain anywhere.
- The child has a cut or burn that is large, deep, and/or won't stop bleeding.
- The child is vomiting blood.
- The child has a severe stiff neck, headache, and fever.
- The child is significantly dehydrated: sunken eyes, lethargic, not making tears, not urinating.
- Multiple children affected by injury or serious illness at the same time.
- When in doubt, call EMS.
- After you have called EMS, remember to contact the child's legal guardian.


**Risk Level**
High

**Corrective Action for 1st Instance**
Citation and CMP Warning

(10) If a child is injured while in care and receives medical attention, or for a child fatality, the provider shall:
(a) submit a completed accident report form to the department within the next business day of the incident; or
(b) contact the department within the next business day and submit a completed accident report form within five business days of the incident.

**Rationale/Explanation**
The licensing agency should be notified according to state regulations regarding any of the events listed above because each involves special action by the licensing agency to protect children, their families, and/or the community. If death, serious injury, or illness or any of the events in item d) occur due to negligence by the caregiver/teacher, immediate suspension of the license may be necessary. Public health staff can assist in stopping the spread of the infectious disease if they are
notified quickly by the licensing agency or the facility. The action by the facility in response to an illness requiring medical attention is subject to licensing review. CFOC 4th ed. Standard 9.4.1.10 p.p. 413.

Compliance Guidelines

• Receiving medical attention means the child is seen (either in person or online) by a health care professional or is assisted by any emergency personnel (police, ambulance, fire department, or EMS).
• An accident report must be submitted according to rule for any child in care who is injured and receives medical attention, including the provider's and caregivers’ children younger than 4 years old.
• The provider may call CCL within 24 hours of a child's injury that required medical treatment, and then submit a report within 5 business days; or in place of the call, the provider may notify CCL within 24 hours by emailing, or submitting the accident report through the provider's Child Care Licensing portal.
• Occasionally, the provider may not know that a child who was injured while in care received medical attention. For example, a parent may have taken their child to the doctor after they left the child care facility, and the provider did not find out until a day or two after the injury occurred. In this case, after being informed that the child received medical attention, the provider must report the incident by the end of CCL's next business day.
• Provider may provide Incident and Accident Report Forms to parents or guardians in a digital format, without a signature of receipt, if the provider has received written permission from the parent or guardian to use this method of communication. This written permission must be kept on site for review by the department.

Risk Level
High
Corrective Action for 1st Instance
Citation and CMP Warning when:
A fatality is not reported to CCL, or is not reported within the required time frame.

Risk Level
Moderate
Corrective Action for 1st Instance
Citation Warning when:
An injury requiring medical attention (not resulting in death) is not reported to CCL.

Risk Level
Low
Corrective Action for 1st Instance
Warning when:
An injury requiring medical attention is reported, but not within the required time frame.
(11) If the provider must leave the children due to an emergency and a background checked covered individual who is at least 18 years old or older is not available to stay with the children, the provider may leave the children in the care of an emergency substitute who:
   (a) is at least 18 years old;
   (b) substitutes the caregiver for the minimum time possible and for less than one business day; and
   (c) signs a written background statement before being left alone with the children.

Rationale/Explanation
The purpose of this rule is to ensure that individuals who have not passed a background screening have minimal unsupervised contact with the children in care.

Supervision is basic to safety and the prevention of injury and maintaining quality child care. Parents/guardians have a contract with caregivers/teachers to supervise their children. CFOC 4th ed Standard 2.2.0.1 p.p.64-66.

Compliance Guidelines
Emergency Substitute Variance
When the caregiver-to-child ratio is out of compliance because a caregiver unexpectedly left, and the provider cannot come into compliance within 45 minutes, CCL may grant an emergency variance to the emergency substitute rules for up to ten working days. This will give the provider time to use an emergency substitute longer than 24 hours until they bring in a new caregiver in order to be in compliance with ratios. This variance will also allow for the use of a 16 or 17-year-old emergency substitute.

To obtain this variance, the provider must:
• Contact their licensor within 24 hours (or contact other CCL staff if the licensor is unavailable), and
• Give CCL the name and/or the Covered Individual Number of the person who left.

Refer to the following guidelines:
• The provider must maintain compliance with supervision rules. A variance for supervision will not be granted.
• All emergency substitutes must sign a written statement that they:
  - Have not been convicted of a felony or misdemeanor;
  - Do not have a substantiated background finding; and
  - Are not being investigated for abuse or neglect by any federal, state, or local government agency.
• The emergency substitute's written statement must be submitted to CCL within 5 working days after the occurrence.
• There is an Emergency Substitute Statement form available for use on the CCL website under Forms and Documents.
An emergency substitute may not be left unsupervised until they have met the requirements to become a caregiver.
A Focus Inspection will be conducted to verify compliance with ratios after the variance expires.

**Risk Level**
High

**Corrective Action for 1st Instance**
Citation and CMP Warning when:
- The emergency substitute was younger than 16 years of age.

**Risk Level**
Moderate

**Corrective Action for 1st Instance**
Citation Warning when:
- The emergency substitute was 16 or 17 years of age

(12) Before leaving for the emergency, the provider shall obtain a signed, written background statement from the emergency substitute stating that the emergency substitute:
- (a) has not been convicted of a felony;
- (b) has not been convicted of a crime against a person;
- (c) is not listed on the state or national sex offender registry; and
- (d) is not being investigated for abuse or neglect by any federal, state, or local government agency.

**Rationale/Explanation**
To ensure their safety and physical and mental health, children should be protected from any risk of abuse or neglect. CFOC 4th ed Standard 1.2.0.1 p.p. 9.

(13) Within five working days after the occurrence, the provider shall submit emergency substitute’s written background statements to the department for review.

**Rationale/Explanation**
The purpose of this rule is to ensure that individuals who have a criminal history do not have contact with children in child care programs as outlined in Utah Code 26-39-404.

**Compliance Guidelines**
- The provider should be aware of each individual’s criminal history before they are allowed contact with the children in care.
- Providers should not use individuals as emergency substitutes if their names are listed on the Utah Sex Offender Registry.
- The emergency substitute’s signed, written statement may be emailed or faxed to CCL, or submitted through the provider’s Child Care Licensing portal.
Risk Level
Moderate

Corrective Action for 1st Instance
Citation Warning
The rules and information in this section are designed to ensure that the child care environment is a healthy one. Keeping the facility clean and sanitary, and washing hands are key factors in preventing and reducing the spread of illness.

Young children sneeze, cough, drool, use diapers and are just learning to use the toilet. They hug, kiss, and touch everything and put objects in their mouths. Illnesses may be spread in a variety of ways, such as by coughing, sneezing, direct skin-to-skin contact, or touching a contaminated object or surface. Respiratory tract secretions that can contain viruses (including respiratory syncytial virus and rhinovirus) contaminate environmental surfaces and may present an opportunity for infection by contact. CFOC 4th ed. Standard 3.3.0.1. pp. 125.

**Cleaning, Sanitizing, and Disinfecting**

One of the most important steps in reducing the spread of infectious diseases in child care settings is cleaning, sanitizing or disinfecting surfaces that could possibly pose a risk to children or staff. Routine cleaning with detergent and water is the most common method for removing some germs from surfaces in the child care setting. However, most items and surfaces in a child care setting require sanitizing or disinfecting after cleaning to further reduce the number of germs on a surface to a level that is unlikely to transmit disease. CFOC 4th ed. Appendix J. p.p. 484.

<table>
<thead>
<tr>
<th>Cleaning</th>
<th>Sanitizing</th>
<th>Disinfecting</th>
</tr>
</thead>
<tbody>
<tr>
<td>Remove all visible dirt, debris, and substances from areas and items that are accessible to children.</td>
<td>Reduce germs on objects to levels that are safe for children by using a sanitizing product or process.</td>
<td>Kill 99.9% of germs on objects by using a disinfecting product or process.</td>
</tr>
</tbody>
</table>

There is a difference between cleaning, sanitizing, and disinfecting.
- Cleaning means to physically remove all visible dirt, debris, and substances from areas and items that are accessible to children.
- Routine cleaning with detergent and water is the most useful method for removing germs from surfaces in the child care setting.

The following are suggestions for the proper cleaning of a child care facility:
- Follow a cleaning schedule to ensure that the facility is cleaned on a regular basis.
- Clean up food and liquid spills promptly.
- Vacuum or sweep carpets and floors often.
- Remove garbage and rubbish from the premises on a daily basis and as needed. CFOC 4th ed. Appendix K. p.p. 491-292.
Sanitizing means to reduce germs on objects to levels that are safe for children by using a sanitizing product or process. Sanitizer is a product that reduces but does not eliminate germs on inanimate surfaces to levels considered safe by public health codes or regulations. A sanitizer may be appropriate to use on food contact surfaces (dishes, utensils, cutting boards, high chair trays), toys that children may place in their mouths, and pacifiers. CFOC, 4th ed. Appendix J. p.p. 484.

When used according to manufacturer instructions, approved methods of sanitizing include:
• Using a steam cleaner, dishwasher, or washing machine.
• Applying an approved sanitizing solution directly to a surface.

The following are approved sanitizers when used as specified by the manufacturer:
• Any product that comes with manufacturer instructions for use as a sanitizer.
• A homemade or other household product if documentation and sanitizing instructions exist from a reputable source such as a university or government agency.
• An essential oil, if the provider has and follows the manufacturer’s instructions for sanitizing.
• A bleach and water solution of ½ tablespoon of chlorine bleach in 1 gallon of water, or a scant ½ teaspoon of chlorine bleach in 1 quart of water. CFOC, 4th ed. Appendix J. pp. 440-441.

If bleach-water is used to sanitize:
• A fresh solution must be made at least every 24 hours. After 24 hours the bleach mixture loses its ability to sanitize. Bleach water may be kept longer than 24 hours if it is tested with a test strip and it registers at least 50 parts per million on the strip.
• The solution must be left on the surface for at least 2 minutes.

- Disinfecting means to kill 99.9% of germs on objects by using a disinfecting product or process. Disinfecting is appropriate for use on non-porous surfaces such as diaper change tables, counter tops, door and cabinet handles, toilets, and sinks used for toileting routines including faucets, knobs, and basins.

Not all cleaning chemicals are safe and appropriate for use in a child care setting. A product that is not chlorine bleach can be used in child care settings IF:
• it is registered with the EPA;
• it is also described as a sanitizer or as a disinfectant;
• it is used according to the manufacturer’s instructions.

The provider and caregivers should be aware of the following guidelines:
• Rubbing alcohol is not an approved sanitizer because it does not kill bacterial spores.
• Cracked or porous surfaces, and surfaces repaired with duct tape or similar materials, cannot be kept clean and sanitary because they trap organic materials in which microorganisms can grow.
• Air filtration systems clean the air of viruses and germs but do not clean and sanitize surfaces.
(1) The provider shall keep the building, furnishings, equipment, and outdoor area clean and sanitary including:
   (a) walls and flooring clean and free of spills, dirt, and grime;
   (b) areas and equipment used for the storage, preparation, and service of food clean and sanitary;
   (c) surfaces free of rotting food or a build-up of food;
   (d) the building and grounds free of a build-up of litter, trash, and garbage;
   (e) frequently touched surfaces, including doorknobs and light switches, cleaned and sanitized; and
   (f) the facility free of animal feces.

Rationale/Explanation
Few young children practice good hygiene. Messy play is developmentally appropriate in all age groups, and especially among very young children, the same group that is most susceptible to infectious disease. These factors lead to soiling and contamination of equipment, furnishings, toys, and play materials. To avoid transmission of disease within the group, these materials must be easy to clean and sanitize. CFOC 4th ed. Standard 5.3.1.4 p.p. 254-255.

Outbreaks of foodborne illness have occurred in child care settings. Many of these infectious diseases can be prevented through appropriate hygiene and sanitation methods. Keeping hands clean reduces soiling of kitchen equipment and supplies. Education of child care staff regarding routine cleaning procedures can reduce the occurrence of illness in the group of children with whom they work. Sponges harbor bacteria and are difficult to clean and sanitize between cleaning surface areas. CFOC 4th ed. Standard 4.9.0.9 p.p. 204.

This practice provides proper sanitation and protection of health, prevents infestations by rodents, insects, and other pests, and prevents odors and injuries. CFOC 4th ed. Standard 5.2.7.2 p.p. 239.

All animal waste and litter should be removed immediately from children’s areas and will be disposed of in a way where children cannot come in contact with the material, such as in a plastic bag or container with a well-fitted lid or via the sewage waste system for feces. CFOC 4th ed. Standard 3.4.2.3 p.p. 130-131.

Compliance Guidelines
• There is a difference between messes made as the consequence of an activity done that day and a chronic buildup of dirt, soil, food, etc. over time where disease-causing bacteria can grow.
• Equipment used for the service of food includes plates, bowls, bottles, sippy cups, and utensils.
• Without leaving children unsupervised for more than 5 minutes, the provider must ensure that any trash, animal feces, and other hazards are removed from the outdoor area before children play outside.

The following conditions will result in a rule violation:
• A spill on a floor that could result in injury
• Mold growing as a result of a buildup of food or other substance
• A visible buildup of dirt, soil, grime, etc. that germs could grow in
• A buildup of cobwebs, bugs, or carpets in need of cleaning, when there is a child with asthma or another known respiratory condition enrolled in the group
• A buildup of litter, trash, or garbage in the building or on the grounds
• Dead animals
• Animal waste in accessible areas of the facility (including animal feces or a build-up of rodent or bird droppings)
• A cleanliness or sanitation violation and there is no other licensing rule that specifically addresses the situation.

The following conditions will not result in a rule violation:
• Litter, trash, and garbage in a container
• Animal feces in a litter box, animal cage, or aquarium
• An animal's waste that is immediately cleaned up if an animal relieves itself in an area being used by children.

Risk Level
Moderate
Corrective Action for 1st Instance
Citation Warning

(2) The provider shall take safe and effective measures to prevent and eliminate the presence of insects, rodents, and other pests.

Rationale/Explanation
Screens prevent the entry of insects, which may bite, sting, or carry disease. Following the use of pesticides, herbicides, fungicides, or other potentially toxic chemicals, the treated area should be ventilated for the period recommended on the product label. For further information about pest control, contact the state pesticide regulatory agency, the Environmental Protection Agency (EPA), or the National Pesticide Information Center. For possible poison exposure, contact the local poison center at 1-800-222-1222. CFOC 4th ed. Standard 5.1.3.3 p.p. 218; Standard 5.2.8.1 p.p. 241-242.

Facilities should adopt an integrated pest management program (IPM) to ensure long-term, environmentally sound pest suppression through a range of practices including pest exclusion, sanitation and clutter control, and elimination of conditions that are conducive to pest infestations. IPM is a simple, common-sense approach to pest management that eliminates the root causes of pest problems, providing safe and effective control of insects, weeds, rodents, and other pests while minimizing risks to human health and the environment. Pest Prevention: Facilities should prevent pest infestations by ensuring sanitary conditions. This can be done by eliminating pest breeding areas, filling in cracks and crevices; holes in walls, floors, ceilings and
Water leads; repairing water damage; and removing clutter and rubbish on the premises. CFOC 4th ed. Standard 5.2.8.1 p.p. 241-242.

**Compliance Guidelines**

It is not out of compliance if:

- Children participate in science activities involving harmless insects.
- Fruit flies, grasshoppers, crickets, and tarantulas are on the premises since they are not a health risk to humans.
- There are spider webs on the premises, unless there is a build up of spider webs and the presence of a poisonous spider is reported or observed in a web. According to Utah State University Extension's *Spiders of Utah*, by Laura Allard and Dr. Frey there are four spiders in Utah that are dangerous to humans - black widow, hobo, brown recluse, and yellow sack spiders.
- A child has bed bug bite marks, since bed bugs could be any other place where the child has been.

If insects, rodents, or other pests are on the premises, but the provider can show that they have 1) scheduled an exterminator, and 2) taken extra measures to ensure that the environment is as clean as possible:

- A rule violation will not be written at the first assessment.
- The provider will have no more than 30 days from the date of the inspection for the issue to be corrected.
- A focus inspection will be conducted to verify that the extermination took place by the scheduled date.
- If the extermination did not take place by the scheduled date or the pests are again on the premises, a rule violation will be written at the focus inspection.

**Risk Level**

Moderate

**Corrective Action for 1st Instance**

Citation Warning

(3) The provider shall clean and sanitize any toys and materials used by children:

(a) at least once a week or more often if needed;
(b) after being put in a child's mouth and before another child plays with the toy; and
(c) after being contaminated by a body fluid.

**Rationale/Explanation**

Contamination of hands, toys and other objects in child care areas has played a role in the transmission of diseases in child care settings. 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. Using a mechanical dishwasher is an acceptable labor-saving approach for sanitizing plastic toys as long as the dishwasher can wash and sanitize the surfaces and dishes and cutlery are not washed at the same time. CFOC 4th ed. Standard 3.3.0.2 p.p.126.
Suggestions for cleaning and sanitizing toys include:
- Toys that children have placed in their mouths or that are otherwise contaminated by a body fluid should be set aside until they are cleaned by hand with water and detergent, rinsed, sanitized, and air-dried; or cleaned in a dishwasher.
- Small toys with hard surfaces can be set aside for cleaning.
- Using a mechanical dishwasher is an acceptable labor-saving approach for sanitizing plastic toys as long as the dishwasher can wash and sanitize the surfaces.

**Compliance Guidelines**
Since toys in child care settings are heavily used, every toy is not expected to be perfectly clean all the time.

**Risk Level**
Moderate

**Corrective Action for 1st Instance**
Citation Warning

**Rationale/Explanation**
Equipment, furnishings, toys, and play materials should have smooth, nonporous surfaces or washable fabric surfaces that are easy to clean and sanitize, or be disposable. CFOC 4th ed. Standard 5.3.1.4 p.p. 254-255.

Many allergic children have allergies to dust mites, which are microscopic insects that ingest the tiny particles of skin that people shed normally every day. Dust mites live in carpeting and fabric but can be killed by frequent washing and use of a clothes dryer or mechanical, heated dryer. CFOC 4th ed Standard 5.3.1.4 p.p. 255.

**Compliance Guidelines**
- Since toys in child care settings are heavily used, every toy is not expected to be perfectly clean all the time.
- Large stuffed animals meant to be used as pillows need to be machine washable or have removable covers that are machine washable.
- Unless accessible to children, stuffed animals that are only used for teaching activities or for decoration are not required to be washed weekly.

**Risk Level**
Low

**Corrective Action for 1st Instance**
Warning
(5) The provider shall clean and sanitize highchair trays before each use.

**Rationale/Explanation**
Although highchair trays can be considered tables, they function as plates for seated children. The tray should be washed and sanitized before and after use. CFOC 4th ed. Standard 4.5.0.2 p.p. 189.

**Compliance Guidelines**
- The highchair tray is cleaned and sanitized before a child is placed in the chair to eat or play.
- Even when a child has only played in the highchair and has not eaten, the tray should be cleaned and sanitized before it is used by another child.

**Risk Level**
Low

**Corrective Action for 1st Instance**
Warning

(6) The provider shall clean and sanitize water play tables or tubs daily if used by the children.

**Rationale/Explanation**
Contamination of hands, toys, and equipment in the room in which play tables are located seems to play a role in the transmission of diseases in child care settings. Proper handwashing, supervision of children, and cleaning and sanitizing of the water table will help prevent the transmission of disease. Children have drowned in very shallow water. CFOC 4th ed. Standard 6.2.4.2 p.p. 294.

**Compliance Guidelines**
This rule applies to water play tables or tubs, not to sensory tables with items, such as rice, beans, or sand in them.

**Risk Level**
Moderate

**Corrective Action for 1st Instance**
Citation Warning

(7) The provider shall clean and sanitize bathroom surfaces including toilets, sinks, faucets, toilet and sink handles, and counters each day the facility is open for business.

**Rationale/Explanation**
Illnesses may be spread by way of:
- Human waste (such as urine and feces);
- Body fluids (such as saliva, nasal discharge, eye discharge, open skin sores, and blood);
- Direct skin-to-skin contact;
• Touching a contaminated object;
• The air (by droplets that result from sneezes and coughs).

Since many infected people carry communicable diseases without symptoms, and many are contagious before they experience a symptom, caregivers/teachers need to protect themselves and the children they serve by carrying out, on a routine basis, standard precautions and sanitation procedures that approach every potential illness-spreading condition in the same way. CFOC 4th ed. Standard 9.2.3.10 p.p. 387-388; Appendix K. p.p. 490-492.

**Compliance Guidelines**

This rule will be considered out of compliance if:
• There is mold or mildew on any bathroom surface.
• Bathroom surfaces are not cleaned and sanitized at least once a day.
• Toilet seats are cracked, broken, or made of foam since they cannot be properly sanitized.

**Risk Level**
Moderate

**Corrective Action for 1st Instance**
Citation Warning

(8) **The provider shall clean and sanitize potty chairs after each use.**

**Rationale/Explanation**
If potty chairs are used, they should be constructed of plastic or similar nonporous synthetic products. Wooden potty chairs should not be used, even if the surface is coated with a finish. The finished surface of wooden potty chairs is not durable and, therefore, may become difficult to wash and disinfect effectively. CFOC 4th ed. Standard 5.4.1.7 p.p. 263.

**Compliance Guidelines**
• A toilet training seat is only considered a potty chair if it collects and holds urine or feces. Toddler toilet seats that are placed over a regular toilet are not considered to be potty chairs.
• Only the seat of the potty chair needs to be cleaned and sanitized when a child just sits on it, but does not go to the bathroom. The entire potty chair must be cleaned and sanitized if it has collected urine or feces.

**Risk Level**
Moderate

**Corrective Action for 1st Instance**
Citation Warning

(9) **The provider shall keep toilet paper in a dispenser that is accessible to children.**

**Rationale/Explanation**
Supplies must be within arm's reach of the user to prevent contamination of the environment with waste, water, or excretion. CFOC 4th ed. Standard 5.6.0.3. p.p. 276.

**Compliance Guidelines**
- Toilet paper is only considered accessible if the child can reach it while sitting on the toilet.
- Toilet paper does not need to be within reach of a child sitting on a potty chair as long as a caregiver is present to hand sheets of toilet paper to the child.
- For young children, providers may hand sheets of toilet paper directly to the child rather than having the toilet paper on a dispenser. If that is the case, a caregiver must always be available to hand out the toilet paper when a young child is toileting.
- As long as children can get toilet paper without holding the toilet paper roll, any type of dispenser may be used.
- Disposable wipes may be used in place of toilet paper as long as they are in a covered dispenser and within reach of the child while on the toilet.
- A roll of toilet paper must be placed in the dispenser as soon as a caregiver discovers that the dispenser is out of paper.

It is a rule violation if:
- Toilet paper cannot be reached by a child who is using the toilet.
- Toilet paper is not kept in a dispenser.
- A toilet has no toilet paper and there are no spare rolls available to replace it.

**Risk Level**
Moderate

**Corrective Action for 1st Instance**
Citation Warning

(10) The provider shall ensure that staff and volunteers wash their hands thoroughly with soap and running water:
   (a) upon arrival;
   (b) before handling or preparing food or bottles;
   (c) before and after eating meals and snacks or feeding a child;
   (d) after using the toilet or helping a child use the toilet;
   (e) after contact with a body fluid;
   (f) when coming in from outdoors; and
   (g) after cleaning up or taking out garbage.

**Rationale/Explanation**
Hand hygiene is the most important way to reduce the spread of infection. Many studies have shown that improperly cleansed hands are the primary carriers of infections. Deficiencies in hand hygiene have contributed to many outbreaks of diarrhea among children and caregivers/teachers in child care centers.
Child care centers that have implemented good hand hygiene techniques have consistently demonstrated a reduction in diseases transmission. When frequent and proper hand hygiene practices are incorporated into a child care center's curriculum, there is a decrease in the incidence of acute respiratory tract diseases. Thorough handwashing with soap for at least twenty seconds using clean running water at a comfortable temperature removes organisms from the skin and allows them to be rinsed away. CFOC 4th ed. Standard 3.2.2.1 p.p. 118.

**Compliance Guidelines**

If there is no visible dirt, grime, or body fluid on their hands, staff and volunteers may use a hand sanitizer instead of soap and water only in the following situations:
- When coming in from outdoors.
- If a snack is handed directly to a distressed child.
- When a caregiver who is in the bathroom supervising does not touch any child or bathroom surface. However, if the caregiver has given any hands-on help, such as lifting a child on or off the toilet, or turning the water on or off, then the caregiver must wash their hands.

**Risk Level**
Moderate

**Corrective Action for 1st Instance**
Citation Warning

(11) **The provider shall ensure that caregivers teach children how to wash their hands thoroughly and oversee handwashing when possible.**

**Rationale/Explanation**

Education of the staff and children regarding hand hygiene and other cleaning procedures can reduce the occurrence of illness in the group of children in care. Staff training and monitoring of hand hygiene has been shown to reduce transmission of organisms that cause disease. Periodic training and monitoring is needed to result in sustainable changes in practice. CFOC 4th ed. Standard 3.2.2.4 p.p. 120.

The following hand hygiene procedures are suggested in Caring for Our Children:
- Check to be sure a clean, disposable paper (or single-use cloth) towel is available;
- Turn on clean, running water to a comfortable temperature;
- Moisten hands with water and apply soap (not antibacterial) to hands;
- Rub hands together vigorously until a soapy lather appears, hands are out of the water stream, and continue for at least twenty seconds (sing Happy Birthday silently twice). Rub areas between fingers, around nail beds, under fingernails, jewelry, and back of hands. Nails should be kept short; acrylic nails should not be worn;
- Rinse hands under clean, running water that is at a comfortable temperature until they are free of soap and dirt. Leave the water running while drying hands;
- Dry hands with the clean, disposable paper or single use cloth towel;
- If taps do not shut off automatically, turn taps off with a disposable paper or single use cloth towel;
• Throw the disposable paper towel into a lined trash container; or place single-use cloth towels in the laundry hamper; or hang individually labeled cloth towels to dry. Use hand lotion to prevent chapping of hands, if desired.
CFOC 4th ed. Standard 3.2.2.2 p.p. 119.

**Compliance**
This rule is out of compliance if the provider fails to ensure children are taught proper handwashing.

**Risk Level**
Low

**Corrective Action for 1st Instance**
Warning

(12) The provider shall ensure that children wash their hands thoroughly with soap and running water:
   (a) upon arrival;
   (b) before and after eating meals and snacks;
   (c) after using the toilet;
   (d) after contact with a body fluid;
   (e) before using a water play table or tub; and
   (f) when coming in from outdoors.

**Rationale/Explanation**
Washing hands before and after eating is especially important for children who eat with their hands. Good handwashing should follow after playing in sandboxes, applying sunscreen and/or insect repellent. Hand hygiene after exposure to soil and sand will reduce opportunities for the ingestion of zoonotic parasites that could be present in contaminated sand and soil. CFOC 4th ed. Standard 3.2.2.1 p.p. 118.

**Compliance Guidelines**
• If there is no visible dirt, grime or body fluid on the hands, children age 2 years and older may use a hand sanitizer if its use is actively supervised by a staff member and only when distressed and a snack is handed directly to them.
• During evacuation drills, if the children go outside and go right back inside they are not required to wash their hands. If the children are allowed to play outside during and after the drills, they are required to wash their hands.
• Handwashing with soap and water is not required for infants if their hands have not come into contact with anything and have no visible dirt or grime. If this is the case, the caregiver may clean the infant’s hands with a baby wipe or soapy washcloth. If a soapy washcloth is used, the cloth must be washed after each use.

**Risk Level**
Moderate
Corrective Action for 1st Instance
Citation Warning

(13) The provider shall ensure that only single-use towels, an electric hand dryer, or individually labeled cloth towels are used to dry hands.

Rationale/Explanation
The proper drying of hands should be an essential component of effective hand hygiene procedures. Coates reported that washing hands with either soap and water or water alone combined with drying on paper towels can effectively remove bacteria from the hands. However, if hands are only shaken dry after washing, some bacteria are likely to remain. Huang, C., Ma, W., & Stack, S. (2012). The Hygienic Efficacy of Different Hand-Drying Methods: A Review of the Evidence. Mayo Clinic Proceedings, 87(8), 791–798.

Compliance Guidelines
This rule only applies to towels for drying hands and not to the types of towels used for other purposes such as cleaning up spills.

Risk Level
Low
Corrective Action for 1st Instance
Warning

(14) The provider shall ensure that if cloth towels are used, cloth towels are:
(a) not shared; and
(b) washed daily.

Rationale / Explanation
The transmission of bacteria is more likely to occur from wet skin than from dry skin; therefore, the proper drying of hands is a key part of effective hand hygiene procedures. If hands are only shaken dry after washing, some bacteria are likely to remain. According to the Mayo Clinic, most studies suggest that paper towels can dry hands efficiently, remove bacteria effectively, and cause less contamination of the bathroom environment, and from a hygiene viewpoint, single-use towels are superior to electric air dryers. Huang, C., Ma, W., & Stack, S. (2012). The Hygienic Efficacy of Different Hand-Drying Methods: A Review of the Evidence. Mayo Clinic Proceedings, 87(8), 791–798.

Compliance Guidelines
• This rule only applies to towels for drying hands and not to the types of towels used for other purposes such as cleaning up spills.
• Electric hand dryers may be used in residential child care facilities.

Risk Level
Low
Rule Violation Corrective Action for 1st Instance
Warning

(15) The provider shall store personal hygiene items, such as toothbrushes, combs, and hair accessories separate, so they do not touch each other, and ensure they are not shared or they are sanitized between each use.

Rationale/Explanation
Respiratory and gastrointestinal infections are common infectious diseases in child care. These diseases are transmitted by direct person-to-person contact or by sharing personal articles such as combs, brushes, towels, clothing, and bedding. Prohibiting the sharing of personal articles and providing space so that personal items may be stored separately helps prevent these diseases from spreading. CFOC 4th ed. Standard 3.6.1.5 p.p. 147.

Compliance Guidelines
• If personal hygiene items are shared they must be sanitized before another child uses the shared item.
• Toothbrush bristles must not touch each other when stored.
• Providers are not required to offer hair brushing or tooth brushing, but if they do, personal hygiene items must be stored and used appropriately.

Risk Level
Low
Corrective Action for 1st Instance
Warning

(16) The provider shall ensure that pacifiers, bottles, and nondisposable drinking cups are:
(a) labeled with each child's name or individually identified; and
(b) not shared, or washed and sanitized before being used by another child.

Rationale/Explanation
Thermometers, pacifiers, teething toys, and similar objects should be cleaned, and reusable parts should be sanitized between uses. Contamination of hands, toys and other objects in child care
areas has played a role in the transmission of diseases in child care settings. CFOC 4th ed. Standard 3.3.0.3 p.p. 126.

**Compliance Guidelines**
Approved methods of identifying each child's pacifier, bottle, and cup include:
- Using the child's initials instead of the child's name.
- Using permanent marker or scratching the child's name or initials into the plastic of the pacifier, bottle, or cup.
- Attaching a pacifier to a child's clothing with a clip and short ribbon, and instead of labeling the pacifier, labeling the clip or ribbon with the child's name or initials.
- Using color-coded pacifiers, bottles, and cups instead of labeling with children's names, if each child is assigned a different color.

Other guidelines that apply to this rule include:
- When a meal is served, if drinking cups are brought to the table for the meal and then removed immediately after the meal to clean and sanitize them, the cups do not need to be labeled with each child's name.
- One way that pacifiers and baby bottles can be effectively sanitized is by submerging them in boiling water for 5 minutes. Visit the [Centers for Disease Control and Prevention](https://www.cdc.gov) for more guidance.

**Risk Level**
Moderate

**Corrective Action for 1st Instance**
Citation Warning

(17) **The provider shall ensure that a child's clothing is promptly changed if the child has a toileting accident.**

**Rationale/Explanation**
Children who are learning to use the toilet may still wet/soil their pull-ups or underwear and clothing. Development is not a straight trajectory, but rather a cycle of forward and backward steps as children gain mastery over their bodies in a wide variety of situations. It is normal and developmentally appropriate for children to revert to immature behaviors as they gain developmental milestones while simultaneously dealing with immediate struggles which they are internalizing. Even for preschool and kindergarten aged children, these accidents happen and these incidents are called 'accidents' because of the frequency of these episodes among normally developing children. It is important for caregivers/teachers to recognize that the need to assist young children with toileting is a critical part of their work and that their attitude regarding the incident and their support of children as they work toward self-regulation of their bodies is a component of teaching young children. CFOC 4th ed. Standard 3.2.1.5 p.p. 117.

**Compliance Guidelines**
Being changed promptly means that as soon as the caregiver is aware that a child has had a
toileting accident:
• The child is changed immediately if spare clothing is available.
• If no spare clothing is available, the child's parent is called and asked to bring spare clothing, and the child is discreetly separated from other children until their parent can bring the clothing.

Risk Level
Moderate
Corrective Action for 1st Instance
Citation Warning

(18) The provider shall ensure that children's clothing that is wet or soiled from a body fluid is:
   (a) washed and dried; or
   (b) placed in a leakproof container that is labeled with the child's name and returned to the parent.

Rationale/Explanation
Children who are learning to use the toilet may still wet/soil their pull-ups or underwear and clothing. To avoid contamination of the environment and/or the increased risk of spreading germs to the other children in the room, do not rinse the soiled clothing in the toilet or elsewhere. Place all soiled garments in a plastic-lined, hands-free plastic bag to be cleaned at the child's home; CFOC 4th ed. Standard 3.2.1.1 p.p.115-116.

Compliance Guidelines
• Plastic grocery and other plastic bags may be used to contain wet or soiled clothing as long as they are leakproof. Grocery or other plastic bags with holes in the bottoms or sides cannot be used because they are not leakproof.
• Containers to store wet or soiled clothing must be inaccessible to children.
• The container does not need to be labeled if put into a child's labeled diaper bag or cubby as long as the diaper bag or cubby is inaccessible.
• If a provider only cares for children from one family, they are not required to label the leakproof container holding the contaminated clothing, but it must be inaccessible.
• Fecal matter may be flushed down the toilet before the contaminated clothing is placed in leakproof container.

Risk Level
Moderate
Corrective Action for 1st Instance
Citation Warning

(19) The provider shall take precautions when cleaning floors, furniture, and other surfaces contaminated by blood, urine, feces, or vomit, and ensure that, except for diaper changes and toileting accidents, staff cleaning these bodily fluids:
(a) wear waterproof gloves;
(b) clean the surface using a detergent solution;
(c) rinse the surface with clean water;
(d) sanitize the surface;
(e) throw away in a leakproof plastic bag the disposable materials, such as paper towels, that were used to clean up the body fluid;
(f) wash and sanitize any nondisposable materials used to clean up the body fluid, such as cleaning cloths, mops, or reusable rubber gloves, before reusing them; and
(g) wash their hands after cleaning up the body fluid.

Rationale/Explanation
Providing first aid in situations where blood is present is an intrinsic part of a caregiver’s/teacher’s job. Split lips, scraped knees, and other minor injuries associated with bleeding are common in child care. All caregivers/teachers who are at risk of occupational exposure to blood or other blood-containing body fluids should be offered hepatitis B immunizations and should receive annual training in Standard Precautions and exposure control planning. Training should be consistent with applicable standards of the Occupational Safety and Health Administration (OSHA) Standard 29 CFR 1910.1030. CFOC 4th ed. Standard 1.4.5.3 p.p. 33.

For more information about cleaning up body fluids, refer to CFOC 4th ed. Appendix L. p.p. 493 and Appendix D. p.p. 460 for information on using and removing disposable gloves when handling body fluids.

Compliance Guidelines
All of the cleaning steps do not need to be followed when only droplets of a body fluid are present. However, if any body fluid pools on the floor or ground, the precautions as described in this rule must be taken.

Risk Level
Moderate

Corrective Action for 1st Instance
Citation Warning

(20) If a child becomes ill while in care, the provider shall:
(a) as soon as the illness is observed or suspected, contact the child's parent or, if the parent cannot be reached, an individual listed as the emergency contact; and
(b) if the child is ill with an infectious disease, make the child comfortable in a safe, supervised area that is separated from the other children until the parent arrives.

Rationale/Explanation
The caregiver/teacher should determine if the illness: a. Prevents the child from participating comfortably in activities; b. Results in a need for care that is greater than the staff can provide without compromising the health and safety of other children; c. Poses a risk of spread of harmful diseases to others. If any of the above criteria are met, the child should be excluded, regardless of
the type of illness. Most conditions that require exclusion do not require a primary health care provider visit before reentering care. CFOC 4th ed. Standard 3.6.1.1 p.p. 141-145.

**Compliance Guidelines**
Symptoms that may indicate an infectious disease include:
- A fever of 101 degrees Fahrenheit or higher for infants younger than 4 months of age, or a fever of 102 degrees Fahrenheit or higher for children age 4 months and older
- An unexplained rash
- Irritability
- Lethargy
- A persistent cough
- Vomiting
- Diarrhea
- Infected eyes with discharge

**Risk Level**
Moderate

**Corrective Action for 1st Instance**
Citation Warning

(21) **The provider shall notify the parents of each child in care if any child, employee, or person in the home has an infectious disease or parasite, on the day the illness is discovered.**

**Rationale/Explanation**
Early identification and treatment of infectious diseases are important in minimizing associated morbidity and mortality as well as further reducing transmission. Notification of parents/guardians will permit them to discuss with their child's primary care provider the implications of the exposure and to closely observe their child for early signs and symptoms of illness. CFOC 4th ed. Standard 3.6.4.2 p.p. 156.

**Compliance Guidelines**
- The provider may verbally notify parents or post a notice in a conspicuous place.
- A child with bed bug bite marks does not mean the child has an infectious disease or parasite. Parents do not need to be notified for a child with bed bug bite marks.

**Risk Level**
Moderate

**Corrective Action for 1st Instance**
Citation Warning

(22) **If any child or employee has an infectious disease, an unusual or serious illness, or a sudden onset of an illness, the provider shall notify the local health department on the day the illness is discovered.**
Rationale/Explanation
Reporting to the health department provides the department with knowledge of illnesses within the community and ability to offer preventive measures to children and families exposed to the outbreak of a disease. In some states, caregivers/teachers may not be a mandatory reporter. In those states, caregivers/teachers are encouraged to report any infectious disease to the responsible health authority. CFOC 4th ed. Standard 9.2.3.3 p.p. 381.

Compliance Guidelines
Utah Law requires that certain diseases and conditions must be reported to a local health department or the Utah Department of Health. For more information, refer to: http://health.utah.gov/epi/reporting/.

Risk Level
Low
Corrective Action for 1st Instance
Warning

(23) To prevent contamination of food, the spread of foodborne illnesses, and other diseases, the provider shall ensure that individuals with an infectious disease or showing symptoms such as diarrhea, fever, coughing, or vomit do not prepare or serve foods.

Rationale/Explanation
Food handlers who are ill can easily transmit their illness to others by contaminating the food they prepare with the infectious agents they are carrying. Frequent and proper handwashing before and after using plastic gloves reduces food contamination. Caregivers/teachers who work with infants and toddlers are frequently exposed to feces and to children with infections of the intestines (often with diarrhea) or of the liver. Education of child care staff regarding handwashing and other cleaning procedures can reduce the occurrence of illness in the group of children with whom they work. CFOC 4th ed. Standard 4.9.0.2 p.p. 200-201.

Compliance Guidelines
Providers and caregivers experiencing the symptoms listed above may not prepare or serve food.

Risk Level
Moderate
Corrective Action for 1st Instance
Citation Warning
This section of rules gives information about how to keep food and the serving of food clean, safe, and developmentally appropriate for infants and children in care.

One of the basic responsibilities of every parent/guardian and caregiver/teacher is to provide nourishing food daily that is clean, safe, and developmentally appropriate for children. Food is essential in any early care and education setting to keep infants and children free from hunger. Children also need freely available, clean drinking water. Feeding should occur in a relaxed and pleasant environment that fosters healthy digestion and positive social behavior. Food provides energy and nutrients needed by infants and children during the critical period of their growth and development. CFOC 4th ed. Introduction 4.1 p.p. 161.

(1) **The provider shall offer a meal or snack to each child age two years old and older at least once every three hours.**

**Rationale/Explanation**
Children younger than 6 years need to be offered food every 2 to 3 hours. Appetite and interest in food varies from one meal or snack to the next. Appropriate timing of meals and snacks prevents children from snacking throughout the day and ensures that children maintain healthy appetites during mealtimes. Snacks should be nutritious, as they often are a significant part of a child's daily intake. CFOC 4th ed. Standard 4.2.0.5 p.p.166.

**Compliance Guidelines**
- According to R430-50-18(4)(a)-(b), the times meals and snacks occur must be posted on a daily schedule.
- The amount of time between meals will be counted from the ending time of one meal to the starting time of the next meal for each individual child. If the daily schedule only lists the meal start times, the time between meals will be counted from start time to start time.
- If meal or snack time directly follows nap time, an extra 30 minutes may be allowed at the end of nap time to allow children time to wake up from their nap and get ready for a snack.
- If a facility is open until 7:00 p.m., there may be up to but not more than four hours between the afternoon meal or snack and the facility's closing time. If the facility is open later than 7:00 p.m., a meal or snack must be offered at least every three hours.
- For children who are in late evening or overnight care, meals do not need to be served after children have gone to bed for the night.

**Risk Level**
Moderate

**Corrective Action for 1st Instance**
Citation Warning
(2) If food for children's meals or snacks is supplied by the provider, the provider shall ensure that:

(a) the meal service meets local health department food service rules;
(b) the foods that are served meet the nutritional requirements of the USDA Child and Adult Care Food Program (CACFP) whether or not the provider participates in the CACFP;
(c) the provider uses the CACFP meal pattern requirements, the standard department-approved menus, or menus approved by a registered dietitian, and that dietitian approval is noted and dated on the menus, and current within the past five years;
(d) the current week's menu is posted for review by parents and the department; and
(e) if not participating or in good standing with the CACFP, keep a six-week record of foods served at each meal and snack.

Rationale/Explanation

Food borne illness and poisoning from food is a common occurrence when food has not been properly refrigerated and covered. Although many such illnesses are limited to vomiting and diarrhea, sometimes they are life-threatening. Restricting food sent to the facility to be consumed by the individual child reduces the risk of food poisoning from unknown procedures used in home preparation, storage, and transport CFOC 4th ed. Standard 4.6.0.1 p.p. 193-194.

The CACFP regulations, policies, and guidance materials on meal requirements provide basic guidelines for sound nutrition and sanitation practices. The CACFP guidance for meals and snack patterns ensures that the nutritional needs of infants and children, including school-aged children through 12 years, are met based on the Dietary Guidelines for Americans as well as other evidence-based recommendations. Programs not eligible for reimbursement under the regulations of CACFP should still use the CACFP food guidance. CFOC 4th ed. Standards 4.2.0.2 p.p. 163.

Planning menus in advance helps to ensure that food will be on hand. Posting menus in a prominent area and distributing them to parents/guardians helps to inform parents/guardians about proper nutrition. Parents/guardians need to be informed about food served in the facility to know how to complement it with the food they serve at home. If a child has difficulty with any food served at the facility, parents/guardians can address this issue with appropriate staff members. Some regulatory agencies require menus as a part of the licensing and auditing process. CFOC 4th ed. Standard 4.2.0.9 p.p. 171.

Compliance Guidelines

Food Service Regulations

• Child care providers that supply, prepare, and/or serve food to children are required to pass a kitchen inspection by the local county health department.
• When any food for the children is prepared in the provider’s kitchen, a kitchen inspection is required. For example, if a parent brings unprepared food (e.g. a box of macaroni and cheese)
for the provider to prepare, the provider must be in compliance with this rule.
• If each parent brings already prepared food for their own child, and it is not prepared at the
facility, a kitchen inspection from the local health department is not required. In this case, the
provider is not considered to be providing food service.

Nutritional Requirements and Menus
• This rule does not apply to food that is used only as a curriculum activity and is not part of the
meal or snack.
• The provider must display the current week’s menu in plain sight, or may post it electronically
(to an app, website, etc.) as long as parents and CCL always have access to the menu.
• If only snacks are served at the facility, a snack menu must still be posted.
• If children receive food from a public school, the provider must have documentation that the
school is in good standing with the CACFP.
• Providers are not in compliance when they wait for children in care to arrive and the children
help plan the meals and snacks for that day and then post the menu after the fact. When the
provider involves children in preparing the menu: 1) it must be planned in advance so an
entire week’s menu is available for parent review, and 2) it must follow an approved menu
plan as described in this rule.

Nonparticipants in CACFP
If not participating or not in good standing with CACFP:
• The provider must maintain a six-week record of snacks even when this is the only food that
the provider offers.
• The required six-week record must be dated so the licensor can determine which foods were
served on which dates.

Risk Level
Low
Corrective Action for 1st Instance
Warning

(3) The provider shall ensure that the individual who serves food to children:
   (a) is aware of the children in their assigned group who have food allergies or
   sensitivities; and
   (b) ensures that the children are not served the food or drink they are allergic or
   sensitive to.

Rationale/Explanation
Food allergy is a growing public health concern. Nearly 6 million or 8% of children have food
allergies with young children affected most. Research suggests that close to half of fatal food
allergy reactions are triggered by food consumed outside the home. For more information, refer
to Food Allergy Research and Education at www.foodallergy.org.
A child's diet may be modified because of food sensitivity, a food allergy, or many other reasons. Food sensitivity includes a range of conditions in which a child exhibits an adverse reaction to a food that, in some instances, can be life-threatening. Modification of a child's diet may also be related to a food allergy, an inability to digest or to tolerate certain foods, a need for extra calories, a need for special positioning while eating, diabetes and the need to match food with insulin, food idiosyncrasies, and other identified feeding issues, including celiac disease, phenylketonuria, diabetes, and severe food allergy (anaphylaxis). In some cases, a child may become ill if he/she is unable to eat, so missing a meal could have a negative consequence, especially for children with diabetes. CFOC 4th ed. Standard 4.2.0.8 p.p. 168-169;

**Compliance Guidelines**
Refer to the following definitions as they apply to this rule:
- A food allergy is an immune system reaction that affects numerous organs in the body and occurs soon after eating a certain food.
- A food sensitivity or intolerance is generally a less serious condition that does not involve the immune system and is often limited to digestive problems.
- A child’s dislike of a particular food without a negative physical reaction is a food preference, not a food sensitivity or allergy.
- A child should never be exposed to something they are allergic to, but providers should know what to do if a child has an allergic reaction. Communicate regularly with parents. Train caregivers to know which symptoms may require over the counter allergy medications, the use of an epi pen, or when to call 911.

**Risk Level**
High
**Corrective Action for 1st Instance**
Citation and CMP Warning when: A child is served a food to which they are allergic or sensitive

**Risk Level**
Moderate
**Corrective Action for 1st Instance**
Citation Warning when: A person who serves food at the facility does not know which children have a food allergy or sensitivity.

(4) The provider may not place children's food on a bare table, and shall serve children's food on dishes, napkins, or sanitary highchair trays, except an individual finger food such as a cracker, which may be placed directly in a child's hand.

**Rationale/Explanation**
Clean food service utensils, napkins, bibs, and tablecloths prevent the spread of microorganisms that can cause disease. The surfaces that are in contact with food must be sanitary. Although
highchair trays can be considered tables, they function as plates for seated children. The tray should be washed and sanitized before and after use. The use of disposable items eliminates the spread of contamination and disease and fosters safety and injury prevention. Single service items are usually porous and should not be washed and reused. Items intended for reuse must be capable of being washed, rinsed, and sanitized. CFOC 4th ed. Standard 4.5.0.2 p.p. 189.

Compliance Guidelines
This rule is to prevent food from being served on a bare table. It is not out of compliance if a child places their food on a bare table after it is served.

Risk Level
Low
Corrective Action for 1st Instance
Warning

(5) If parents bring food and drink for their child's use, the provider shall ensure that the food is:
   (a) labeled with the child's name;
   (b) refrigerated if needed; and
   (c) consumed only by that child.

Rationale/Explanation
Restricting food sent to the facility to be consumed by the individual child reduces the risk of food poisoning from unknown procedures used in home preparation, storage, and transport. Food brought from home should be nourishing, clean, and safe for an individual child. In this way, other children should not be exposed to unknown risk. Inadvertent sharing of food is a common occurrence in early care and education. The facility has an obligation to ensure that any food offered to children at the facility or shared with other children is wholesome and safe as well as complying with the food and nutrition guidelines for meals and snacks that the early care and education program should observe. The facility, in collaboration with parents/guardians and the food service staff/nutritionist/registered dietitian, should establish a policy on foods brought from home for celebrating a child's birthday or any similar festive occasion. CFOC 4th ed. Standard 4.6.0.1 p.p. 193-194.

Compliance Guidelines
• The food and drink may be labeled with only the child's first name unless another child in the facility has that same first name. In this case, the food and drink must be labeled with the child's first name and last name initial unless another child has the same first name and last initial. If this is the case, the food and drink must be labeled with the child's full name.
• Instead of being refrigerated, the food and drink may be kept in a lunch container with a cold pack, as long as the cold pack stays at least cool to the touch.
• Food that is brought from home may be put in a cubby that is labeled with the child's first name as long as the food is kept cold as necessary.
• It is the provider's responsibility to determine by policy if on special occasions parents may
bring food to share with children other than their own. If allowed, only commercially prepared and packaged foods may be shared since the provider usually does not know how parents prepare and store food.

**Risk Level**
Low

**Corrective Action for 1st Instance**
Warning
This section provides rules and information about storing and administering medication to children in care. The intent of these rules is to help providers avoid harm to children caused by an error in administering medication, and to prevent children from accessing and ingesting a medication without adult supervision. A provider's policies on administering medications should comply with the requirements of the American with Disabilities Act (ADA). For more information about this law, refer to: www.ada.gov.

Consider a substance (other than food and water) to be a medication if it is taken into the body or is a prescription and is placed on the body in order to:
• Affect how the body functions,
• Treat or cure a medical condition,
• Relieve pain or symptoms of illness, and/or
• Prevent infection, illness, or disease.

Products that are used on the body and were obtained without a prescription are not assessed as medication. This includes but is not limited to sunscreen, diaper cream, aloe vera, lotion, and neosporin.

With a few exceptions, CCL considers a substance that meets any of the above criteria to be a medication. In addition to all prescription medications and over-the-counter medications, the following are examples of products that are considered to be medications because they affect how the body functions.

• Baby powder (that contains talc)
• Energy drinks
• Essential oils (not in a diffuser)
• Herbal remedies
• Hydrogen peroxide (more than 3% strength)
• Ipecac syrup
• Relaxation drinks (e.g. Chillax)
• Rubbing alcohol
• Simethicone gas drops or pills
• Teething gels
• Vitamins
• Weight loss liquid drinks (when labeling implies the product is used for weight loss)

(1) The provider shall make medications inaccessible to children in care.

Rationale/Explanation
Medicines can be crucial to the health and wellness of children. They can also be very dangerous if the wrong type or wrong amount is given to the wrong person or at the wrong time. Prevention is the key to prevent poisonings by making sure medications are inaccessible to children. CFOC 4th ed. Standard 3.6.3.1 p.p.153.

Compliance Guidelines
All medications must be stored according to rule including:
- Medications in first aid kits.
- Employees' and household members' medications.
- Medications in purses, backpacks, diaper bags, etc.

- The purse, backpack, etc. must be inaccessible or the medication should be removed and made inaccessible.
- A backpack, fanny pack, etc. being worn by an adult is considered inaccessible.
- A medication's child-resistant packaging, such as a safety cap, does not make the medication inaccessible to children.

Risk Level
Moderate
Corrective Action for 1st Instance
Citation Warning

(2) The provider shall lock refrigerated medications or store them at least 36 inches above the floor and, if liquid, store them in a separate leakproof container

Rationale/Explanation
Child-resistant safety packaging has been shown to significantly decrease poison exposure incidents in young children. Proper disposal of medications is important to help ensure a healthy environment for children in our communities. There is growing evidence that throwing out or flushing medications into our sewer systems may have harmful effects on the environment. CFOC 4th ed. Standard 3.6.3.2 p.p. 154.

Compliance Guidelines
- Each liquid medication in the refrigerator (even one that does not require refrigeration) must be stored in a separate leakproof container such as a:
  - Plastic container with a lid,
  - Closed ziplock bag, or
  - Refrigerator drawer if all sides of the drawer are taller than its surface and able to contain a spill, there are no openings or cracks in the drawer, and nothing else is stored in the drawer.

It is acceptable if:
- A vial of medication is not in a separate leakproof container if the medication can only be removed with a hypodermic needle.

Risk Level
Moderate
Corrective Action for 1st Instance
Citation Warning

(3) If parents supply any over-the-counter or prescription medications, the provider shall ensure those medications are:
(a) labeled with the child's full name;
(b) kept in the original or pharmacy container;
(c) have the original label; and
(d) have child safety caps.

Rationale/Explanation
Caregivers/teachers need to know what medication the child is receiving, who prescribed the medicine and when, for what purpose the medicine has been prescribed and what the known reactions or side effects may be if a child has a negative reaction to the medicine. A child's reaction to medication can be occasionally extreme enough to initiate the protocol developed for emergencies. The medication record is especially important if medications are frequently prescribed or if long-term medications are being used. CFOC 4th ed. Standard 3.6.3.3 p.p. 154-155.

Compliance Guidelines
• The child's full name can be on the medication, on a bag containing the medication, or on a medication permission form attached to a bag containing the medication.
• Loose pills may not be stored in a ziplock bag and a liquid medication may not be mixed with another liquid in a bottle.
• If a medication is in the original container without a child-safety cap (such as eye drops or nasal spray) it must still have the original label and be labeled with the child's name.
• If a parent supplies an over-the-counter medication for several of their children, the medication needs to be labeled with the last name and the first name of each child who may be given the medication.
• A medication or medical device (such as an inhaler) that has the pharmacy label, with the child's full name on it, does not need to be kept in the original box.
• Epinephrine injectors (commonly referred to as EpiPens) provided by parents must be properly labeled.

The following are suggestions for labeling a small container of medication, such as a small vial:
• Keep the container in the box that has the required information on it.
• Write the name on the bottom of the medication container.
• Use a clear address label.
• Attach a label to a twist tie or zip tie and attach the tie around the neck of the medication container.
• Keep the vial in a labeled container.

Risk Level
High
Corrective Action for 1st Instance
Citation and CMP Warning when:
A medication has been given to the wrong child due to noncompliance with this rule.

Risk Level
Moderate
Corrective Action for 1st Instance
Citation Warning otherwise.

(4) The provider shall have a written medication permission form completed and signed by the parent before administering any medication supplied by the parent for their child.

Rationale/Explanation
The file for each child should include a medication record maintained on an ongoing basis by designated staff for all prescription and non-prescription (over-the-counter [OTC]) medications. State requirements should be checked and followed. CFOC 4th ed. Standard 9.4.2.6 p.p. 422.

A curriculum for child care providers on safe administration of medications in child care is available from the American Academy of Pediatrics.

Compliance Guidelines
• There must be a written permission form signed by the parent for each medication to be given to their child. This applies to both over-the-counter and prescription medications, whether they will be administered one time or on an ongoing basis.
• If the same medication will be administered on an ongoing basis, only one completed permission form is required as long as the administration instructions do not change.
• The permission form may be hardcopy or electronic.
• The signature may be handwritten or digital.

Risk Level
Moderate
Corrective Action for 1st Instance
Citation Warning

(5) The provider shall ensure that the medication permission form includes at least:
(a) the name of the child;
(b) the name of the medication;
(c) written instructions for administration; and
(d) the parent signature and the date signed.

Rationale/Explanation
Administration of medicines is unavoidable as increasing numbers of children entering child care take medications. National data indicate that at any one time, a significant portion of the pediatric population is taking medication, mostly vitamins, but between 16% and 40% are taking antipyretics/analgesics. Safe medication administration in child care is extremely important and training of caregivers/teachers is essential. CFOC 4th ed. Standard 3.6.3.3 p.p. 155.

Risk Level
Low
Corrective Action for 1st Instance
Warning

(6) The provider shall ensure that instructions for administering the medication include at least:
   (a) the dosage;
   (b) how the medication will be given;
   (c) the times and dates to administer the medication; and
   (d) the disease or condition being treated

Rationale/Explanation
Before assuming responsibility for giving any medication to a child, the provider must have clear, accurate written instructions on how the medication should be administered and information about the child’s disease or condition. CFOC 4th ed. Standard 9.4.2.6 p.p. 420-421.

Compliance Guidelines
The provider may use two separate forms or combine the medication permission form and the medication administration form into a single form as long as the combined form has all required information.

Risk Level
Moderate

Corrective Action for 1st Instance
Citation Warning

(7) If the provider supplies an over-the-counter medication for children’s use, the provider shall ensure that the medication is not administered to any child without previous parental consent for each instance it is given. The provider shall ensure that the consent is:
   (a) written; or
   (b) verbal, if the date and time of the consent is documented and signed by the parent upon picking up their child.

Rationale/Explanation
Over the counter medications, such as acetaminophen and ibuprofen, can be just as dangerous as prescription medications and can result in illness or even death when these products are misused or unintentional poisoning occurs. Many children’s over the counter medications contain a combination of ingredients. It is important to make sure the child isn’t receiving the same medications in two different products which may result in an overdose. Facilities should not stock OTC medications. CFOC 4th ed. Standard 3.6.3.1 p.p. 153.

Risk Level
High

Corrective Action for 1st Instance
Citation and CMP Warning
(8) The provider shall ensure that the staff administering the medication:
   (a) washes their hands;
   (b) check the medication label to confirm the child's name if the parent supplied the
       medication;
   (c) checks the medication label or the package to ensure that a child is not given a
       dosage larger than that recommended by the health care professional or
       manufacturer; and
   (d) administers the medication.

Rationale/Explanation
All medicines require clear, accurate instruction and medical confirmation of the need for the
medication to be given while the child is in the facility. CFOC 4th ed. Standard 3.6.3.1 p.p. 153.

Compliance Guidelines
The caregiver administering the medication may:
• Give a medication dosage different from the manufacturer recommendation if the parent
  provides a doctor's note confirming the dosage.
• Refer to a doctor's note if the medication does not have a dosage chart.
• Put the medication in a food source, such as crushing a pill and putting it in juice or
  applesauce, as instructed by the parent.

Risk Level
High
Corrective Action for 1st Instance
Citation and CMP Warning when any of the following occurs due to noncompliance with this
rule:
• Medication is given to the wrong child.
• A child misses a dose of medication.
• A child receives more medication than what is recommended by the health care professional
  or manufacturer.

Risk Level
Moderate
Corrective Action for 1st Instance
Citation Warning otherwise.

(9) The provider shall ensure that immediately after administering a medication, the staff
giving the medication records the following information:
   (a) the date, time, and dosage of the medication given;
   (b) any error in administering the medication or adverse reactions; and
   (c) their signature or initials.

Compliance Guidelines
• If a provider cares for a child with diabetes who uses an insulin pump, the caregiver must
document each time they deliver medication with the pump. If the pump keeps records of the dosage and time the dosage is given, the provider will not be required to document each time the insulin is administered.

• Records may be hardcopy or electronic.
• The signature or initials may be handwritten or digital.
• If an app is used and the individual who enters information into the app can be determined by app data, that will satisfy the need for a signature or initials.

**Risk Level**
High

**Corrective Action for 1st Instance**
Citation and CMP Warning when:
Failure to document the required information resulted in a child being given an extra dose or missing a needed dose of medication.

**Risk Level**
Moderate

**Corrective Action for 1st Instance**
Citation Warning otherwise.

(10) The provider shall report to the parent a child's adverse reaction to a medication or error in administration of the medication immediately upon recognizing the reaction or error, or after notifying emergency personnel if the reaction is life-threatening.

**Rationale/Explanation**
Caregivers/teachers need to know what medication the child is receiving, who prescribed the medicine and when, for what purpose the medicine has been prescribed and what the known reactions or side effects may be if a child has a negative reaction to the medicine. A child's reaction to medication can be occasionally extreme enough to initiate the protocol developed for emergencies. The medication record is especially important if medications are frequently prescribed or if long-term medications are being used. CFOC 4th ed. Standard 3.6.3.3 p.p. 155.

**Risk Level**
High

**Corrective Action for 1st Instance**
Citation and CMP Warning

(11) The provider shall notify the parent before the time a medication needs to be given to a child if the provider chooses not to administer medication as instructed by the parent.

**Rationale/Explanation**
The intent of this rule is to prevent miscommunication between the provider and parent that
could jeopardize the child's health. For example, a parent could drop their child off at the facility thinking that their child will receive a needed medication while in care, but in fact the child will not be given the medication.

**Compliance**
Medication that a child needs due to a chronic medical condition or disability must be accommodated by the provider.

**Risk Level**
High

**Corrective Action for 1st Instance**
Citation and CMP Warning when:
The provider fails to inform the parent of their refusal to administer a medication before it needs to be given to the child, and the child's condition is life-threatening without the medication.

**Risk Level**
Moderate

**Corrective Action for 1st Instance**
Citation Warning otherwise.

(12) The provider shall keep a six-week record of medication permission and administration forms on-site for review by the department.

**Rationale/Explanation**
The health and safety of individual children requires that information regarding each child in care be kept and made available on a need-to-know basis. Prior informed, written consent of the parent/guardian is required for the release of records/information (verbal and written) to other service providers, including process for secondary release of records. Consent forms should be in the native language of the parents/guardians, whenever possible, and communicated to them in their normal mode of communication. CFOC 4th ed. Standards 9.4.2.1 p.p. 418-419.

**Compliance Guidelines**
Records may be kept as a hard copy or electronically.

**Risk Level**
Low

**Corrective Action for 1st Instance**
Warning
This section provides the rules and information about daily activities and schedules. It also discusses the rules that the provider must follow if offsite activities are offered for the children.

(1) The provider shall offer daily activities that support each child's healthy physical, social, emotional, cognitive, and language development.

**Rationale/Explanation**
Research in early brain development has demonstrated the importance of offering children repeated and varied activities. Children’s experiences in their earliest years affect how their brains work and during these years the brain undergoes its most dramatic growth. Language emerges, basic motor abilities form, thinking becomes more complex, and children begin to understand their own feelings and those of others. Children who do not receive appropriate nurturing or stimulation during these prime times are at heightened risk for developmental delays and impairments. Rethinking the Brain. Rima Shore (NY: Families and Work Institute, 1997); What Do We Know About Social and Emotional Development (The Urban Child Institute, 2017).

<table>
<thead>
<tr>
<th>Physical Development</th>
<th>Social/Emotional Development</th>
<th>Cognitive Development</th>
<th>Language Development</th>
</tr>
</thead>
<tbody>
<tr>
<td>Crawling</td>
<td>Feeling</td>
<td>Thinking</td>
<td>Talking</td>
</tr>
<tr>
<td>Walking</td>
<td>Expressing</td>
<td>Understanding</td>
<td>Listening</td>
</tr>
<tr>
<td>Running</td>
<td>Succeeding</td>
<td>Guessing</td>
<td>Singing</td>
</tr>
<tr>
<td>Dancing</td>
<td>Sharing</td>
<td>Asking</td>
<td>Role Playing</td>
</tr>
<tr>
<td>Climbing</td>
<td>Playing</td>
<td>Answering</td>
<td>Reading</td>
</tr>
<tr>
<td>Balancing</td>
<td>Laughing</td>
<td>Solving</td>
<td>Writing</td>
</tr>
<tr>
<td>Exercising</td>
<td>Pretending</td>
<td>Exploring</td>
<td>Rhyming</td>
</tr>
<tr>
<td>Writing</td>
<td>Encouraging</td>
<td>Learning</td>
<td>Reciting</td>
</tr>
<tr>
<td>Drawing</td>
<td>Helping</td>
<td>Evaluating</td>
<td>Responding</td>
</tr>
</tbody>
</table>

Positive early childhood experiences are crucial for healthy development, particularly during the first five years of life. The following state resources are recommended and available to create or strengthen early learning activity plans:
- Utah Core Competencies Guide
- Utah’s Early Learning Guide (Birth to 3)
- Utah’s Early Learning Standards: Ages Three to Five

**Risk Level**
Moderate

**Corrective Action for 1st Instance**
(2) The provider shall ensure that physical development activities include light, moderate, and vigorous physical activity for a daily total of at least 15 minutes for every two hours children spend in the program.

Rationale/Explanation
The facility should promote all children’s active play every day. Children should have ample opportunity to do moderate to vigorous activities, such as running, climbing, dancing, skipping, and jumping, to the extent of their abilities. CFOC 4th ed. Standard 3.1.3.1 p.p. 97-98.

Examples
Light physical activity: Building with large blocks, rolling cars around the floor, and physical games of make believe.
Moderate physical activity: Yoga, indoor exercise, walking, and movement games.
Vigorous physical activity: Running, climbing, jumping rope and playing sports.

Compliance Guidelines
If children do not have regular opportunities to move freely this rule will be out of compliance.

Risk Level
Moderate
Corrective Action for 1st Instance
Citation Warning

(3) The provider shall ensure that toys, materials, and equipment needed to support children’s healthy development are available to the children.

Rationale/Explanation
Staff should ensure that children and parents/guardians understand the need for a safe indoor and outdoor learning/play environment and feel comfortable when playing indoors and outdoors. CFOC 4th ed. Standards 2.1.1.1 - 2.1.1.2 p.p. 51-52.

Good-quality toys, books, and equipment not only benefit children, they can make child care much easier to manage. A few tips for choosing toys and materials include:
• Choose toys that are durable and safe. Look at labels. Think big – no small parts for younger children.
• Have enough toys and materials to occupy all children in attendance.
• Select toys that can be used in a variety of ways.
• Promote healthy development by providing toys that encourage large-motor, small-motor and thinking skills, as well as social skills and self-awareness.

Compliance Guidelines
There must be enough materials for each child in the group to be engaged in play with at least
one toy or activity.

**Risk Level**
Moderate

**Corrective Action for 1st Instance**
Citation Warning

(4) Except for occasional special events, the provider shall ensure that the children's primary screen time activity on media such as television, cell phones, tablets, and computers is:
   (a) not allowed for children zero to 17 months old;
   (b) limited for children 18 months to four years old to one hour a day, or five hours a week with a maximum screen time of two hours per activity; and
   (c) planned to address the needs of children five to 12 years old.

**Rationale/Explanation**
The first two years of life are critical periods of growth and development for children’s brains and bodies, and rapid brain development continues through the early childhood years. To best develop their cognitive, language, motor, and social-emotional skills, infants and toddlers need hands-on exploration and social interaction with trusted caregivers. Digital media viewing does not promote such skills development as well as “real life”. Excessive media use has been associated with lags in achievement of knowledge and skills, as well as negative impacts on sleep, weight, and social/emotional health. CFOC 4th ed. Standard 2.2.0.3 p.p. 70.

According to the Mayo Clinic and the AAP, too much or poor quality screen time has been linked to these negative health effects:
• Lack of adequate sleep
• Obesity
• Substance Abuse
• Behavioral problems
• Decreased school performance
• Loss of social skills
• Less time for essential play
• Violence

**Compliance Guidelines**
• Children who are younger than 18 months old should never be placed in front of a screen to be entertained or occupied. Screen time should never be the primary activity for children this age.
• In mixed-age groups, older children may participate in screen time activities when children younger than 18 months old are present on condition that the primary activity of the young children is not screen time. For example, an infant may be fed or rocked to sleep, or a young child may be playing with toys in the room where older children participate in a screen activity, as long as watching the screen is not the infant's or younger child's primary activity.
• Occasional special events include events that the entire center participates in, like a party, holiday celebration, parent presentation or graduation ceremony that may include the use of screens.
• Although experts advise that screen time for school-age children be limited to 1 to 2 hours per day (including at home), licensing rule does not specify a maximum number of screen time hours for this age group. Instead, the provider should develop a plan for managing screen time such as allowing a certain amount of screen time for homework and for free play.

This rule does not pertain to screen time that:
• Involves children in physical activity, for example, when children watch television to exercise, dance, or do yoga.
• Is interactive and engages a group of children along with their caregivers, for example, watching an educational video that involves questions and answers or problem-solving with others.

Risk Level
Moderate
Corrective Action for 1st Instance
Citation Warning

(5) If swimming activities are offered or if wading pools are used, the provider shall ensure that:
(a) the parent gives permission before their child in care uses the pool;
(b) caregivers stay at the pool supervising when a child is in the pool or has access to the pool, and when an accessible pool has water in it;
(c) diapered children wear swim diapers when they are in the pool;
(d) wading pools are emptied and sanitized after use by each group of children;
(e) if the pool is over four feet deep, there is a lifeguard on duty who is certified by the Red Cross or other approved certification program any time children have access to the pool; and
(f) lifeguards and pool personnel do not count toward the caregiver-to-child ratio.

Rationale/Explanation
Drowning is the second leading cause of unintentional injury-related death for children ages one to fourteen. In 2006, approximately 1,100 children under the age of twenty in the U.S. died from drowning.

Constant and active supervision should be maintained when any child is in or around water. During any swimming/ wading/ water play activities where either an infant or a toddler is present, the ratio should always be one adult to one infant/toddler. Children ages thirteen months to five years of age should not be permitted to play in areas where there is any body of water, including swimming pools, ponds and irrigation ditches, built-in wading pools, tubs, pails, sinks, or toilets unless the supervising adult is within an arm's length providing “touch supervision”. CFOC 4th ed. Standards 2.2.0.4.- 2.2.0.5 p.p. 68-6971-72.
It is recommended that the provider check with their local health department before allowing children to use a wading pool because some health departments prohibit the use of wading pools in child care facilities. Licensing rule requires providers to comply with local laws and rules such as these.

This practice provides control of bacteria and algae and enhances the participants' comfort and safety. Maintaining pH and disinfectant levels within the prescribed range suppresses bacterial growth to tolerable levels. CFOC 4th ed. Standard 6.3.4.1 p.p. 302.

Constant and active supervision should be maintained when any child is in or around water. During any swimming/wading/water play activities where either an infant or a toddler is present, the ratio should always be one adult to one infant/toddler. The required ratio of adults to older children should be met without including the adults who are required for supervision of infants and/or toddlers. An adult should remain in direct physical contact with an infant at all times during swimming or water play. Whenever children thirteen months and up to five years of age are in or around water, the supervising adult should be within an arm’s length providing “touch supervision”. Water play includes wading. Touch supervision means keeping swimming children within arm’s reach and in sight at all times. Drowning is a “silent killer” and children may slip into the water silently without any splashing or screaming. Ratios for supervision of swimming, wading and water play do not include personnel who have other duties that might preclude their involvement in supervision during swimming/wading/water play activities while they are performing those duties. CFOC 4th ed. Standard 1.1.1.5 p.p. 7.

**Compliance Guidelines**

- Whenever a wading pool contains water, a caregiver must stay at the pool. If the caregiver needs to leave, the pool must be enclosed within a 4-foot-high fence, or it must be emptied. The pool may never be left with water in it, even when there are no children in the outdoor area.
- If the pool is over 4 feet deep, a caregiver may not act as a lifeguard and count in the caregiver-to-child ratio at the same time.

**Risk Level**

High

**Corrective Action for 1st Instance**

Citation and CMP Warning when:

Children have unsupervised access to a pool or a wading pool with water in it.

**Risk Level**

Moderate

**Corrective Action for 1st Instance**

Citation Warning otherwise.

(6) If offsite activities are offered, the provider shall ensure that:

Section 18 - Activities
(a) the parent gives written consent before each activity;
(b) the required caregiver-to-child ratio and supervision are maintained during the entire activity;
(c) first aid supplies, including at least antiseptic, bandages, and tweezers are available;
(d) children's names are not used on nametags, t-shirts, or in other visible ways; and
(e) there is a way for caregivers and children to wash their hands with soap and water, or with wet wipes and hand sanitizer if there is no source of running water.

Rationale/Explanation
These records and reports are necessary to protect the health and safety of children in care. CFOC 4th ed. Standard 9.4.2.3 p.p. 420.

Injuries are more likely to occur when a child's surroundings or routine changes. Activities outside the facility may pose increased risk for injury. When children are excited or busy playing in unfamiliar areas, they are more likely to forget safety measures unless they are closely supervised at all times. CFOC 4th ed. Standard 6.5.1.1 p.p. 308.

The facility should maintain first aid and emergency supplies in each location where children are cared for. The first aid kit or supplies should be kept in a closed container, cabinet, or drawer that is labeled and stored in a location known to all staff, accessible to staff at all times, but locked or otherwise inaccessible to children. When children leave the facility for a walk or to be transported, a designated staff member should bring a transportable first aid kit. In addition, a transportable first aid kit should be in each vehicle that is used to transport children to and from a child care facility. CFOC 4th ed. Standard 5.6.0.1 p.p. 274-775.

During offsite activities children should not have their names on shirts, badges, or other visible ways. This practice prevents a stranger from calling a child by name to lure them into a dangerous situation. Children are more likely to respond to a stranger who calls them by name.

Thorough handwashing with soap for at least twenty seconds using clean running water at a comfortable temperature removes organisms from the skin and allows them to be rinsed away. Hand hygiene with an alcohol-based sanitizer is an alternative to traditional handwashing with soap and water when visible soiling is not present. CFOC 4th ed. Standard 3.2.2.2 p.p. 118.

Compliance Guidelines
Parental Permission
• Parents may give a general permission on the admission form for their child to be transported on field trips, but this blanket statement does not meet the requirement of this rule.
• In advance of each offsite activity, the provider must inform parents 1) where the children will be going, including any alternative or backup locations, 2) the day and time they will be offsite, and 3) how the children will get there and back. The provider must receive parent’s written consent before each activity.
• Permission may be obtained and kept as either a hardcopy or electronic file.
• For recurring and regularly scheduled offsite activities, parents may sign one permission
form for the activities as long as the parents are given all of the required information as stated above. For example, the provider may get permission to take the children to the library every Tuesday morning at 10:00 a.m.

• For occasional spontaneous walking field trips, prior written parental permission is not required if 1) the children are offsite for no longer than 60 minutes, 2) they are within ½ mile of the facility, and 3) a notice is posted that includes the times they left and will return, where they will be going, and the route they will take to and from that location.

**Ratios and Supervision**

• During offsite activities (including in a car or on a field trip), children must always be under the active supervision of a caregiver or volunteer who has passed a background check and meets the other personnel requirements as described in rule.

• Parent volunteers may not count in the ratio or have unsupervised contact with any children except their own unless the parent has passed a CCL background check.

**Handwashing**

• Caregivers and children should use soap and running water if available.

• Caregivers must closely supervise the children’s use of hand sanitizer to prevent potential ingestion or accidental contact of the hand sanitizer with eyes, nose and mouth.

• Pre-moistened cleansing towelettes do not effectively clean hands and should not be used as a substitute for handwashing.

• For more information on handwashing, see “Section 15: Health and Infection Control.”

**Risk Level**

High

**Corrective Action for 1st Instance**

Citation and CMP Warning when:

The required caregiver-to-child ratio and/or supervision was not maintained.

Moderate

**Corrective Action for 1st Instance**

Citation Warning otherwise.

(7) The provider shall ensure that a caregiver with the children takes the written emergency information and releases for each child in the group on each offsite activity, and that the information includes at least:

(a) the child’s name;

(b) the parent’s name and phone number;

(c) the name and phone number of an individual to notify if an emergency happens and the parent cannot be contacted;

(d) the names of people authorized by the parents to pick up the child; and

(e) current emergency medical treatment and emergency medical transportation releases.
**Rationale/Explanation**
Caregivers/teachers must have written parental permission to allow them access to information they and emergency medical services personnel may need to care for the child in an emergency. CFOC 4th ed. Standard 9.4.2.2 p.p. 419.

**Compliance Guidelines**
- Caregivers must have children's emergency information and releases with them each time they take children offsite including on walks, and going to and from school.
- The emergency information must be complete in accordance with this rule.
- Caregivers must have a paper copy of each child's emergency information. Having only an electronic copy could result in critical information being inaccessible to emergency personnel and others who may need it.

**Risk Level**
Moderate

**Corrective Action for 1st Instance**
Citation Warning
Although active play is critical for children's health, the active play areas of a child care facility are associated with frequent and severe injuries. The rules in this section are intended to prevent injuries related to indoor and outdoor play equipment. They are based on standards set by the Consumer Product Safety Commission (CPSC), the American Society for Testing and Materials (ASTM), the American Academy of Pediatrics (AAP), and the American Public Health Association (APHA).

These rules apply to indoor and outdoor stationary play equipment rather than moveable equipment (e.g. balls, riding toys, sensory table, sand/water toys, push/pull toys, hoops). Stationary play equipment has a base that is meant to keep the equipment fixed in one location when a child uses it. Examples of stationary play equipment include:

- Climbers (including plastic climbers and indoor vinyl-covered foam climbers)
- Slides
- Swings (except porch and patio swings)
- Sensory swings
- Spring rockers
- Inflatable bounce houses
- Raised tunnels and tunnels with handles children use for climbing
- Inner tube jumpers (they are not assessed as trampolines)
- Teeter-totters
- Roller coasters
- Climbing walls
- A merry-go-round (a revolving piece of equipment for children to ride on)
- A playhouse or treehouse that has an attached component such as a slide, swing, or climber unless the component is inaccessible
- A tree, if a component such as a rope or swing, is attached to the tree for the children to play on
- Multiple stumps, disks, boulders, or pillars that are installed in the ground and are intended for children to step on from one to the other

If a facility has stationary play equipment, the provider must ensure compliance with licensing rules or ensure children in care do not use the play equipment. All play equipment and associated use zones that are used by children will be inspected.

As stated in “Section 2: Definitions,” a use zone is the area beneath and surrounding a play structure or piece of equipment that is designated for unrestricted movement around the equipment, and onto which a child falling from or exiting the equipment could be expected to land.

The following items are not assessed as stationary play equipment:

- Slides that exit into swimming pools
- Carpeted ramps
A tunnel that sits on the ground or floor and is used only as a tunnel and has no handles for climbing
A tunnel with a height of 18 inches or lower even if it has handles or holes for climbing
A natural structure unless it has attached play equipment such as a slide or climber
Stumps or similar objects that are used only for seating
Portable stumps that children can move around

Refer to “Section 9: Facility” to review the rules and guidelines about play equipment maintenance.

(1) The provider shall ensure that children using play equipment use it safely and in the manner intended by the manufacturer.

Rationale/Explanation
Children like to test their skills and abilities. This is particularly noticeable around playground equipment. Even if the highest safety standards for playground layout, design and surfacing are met, serious injuries can happen if children are left unsupervised. Adults who are involved, aware, and appreciative of young children’s behaviors are in the best position to safeguard their well-being. CFOC 4th ed. Standard 2.2.0.1 p.p. 68-69.

Caregivers should ensure that children are using equipment that is appropriate for their age.

Compliance Guidelines
Caregivers must prevent children from engaging in activities such as:
• Going down a slide head first
• Playing or being on parts of the equipment not intended for use, such as:
  - Climbing on or walking across the top of a swing set
  - Climbing up the outside of covered slides or other equipment
  - Playing on the roof of a composite structure
  - Climbing or playing on a tunnel not meant for climbing
  - Climbing or walking on top of protective barriers
• Using equipment that is inappropriate for their age

Additional guidelines:
• If a caregiver is actively preventing or immediately stopping children from using equipment in an inappropriate or unsafe manner, this rule is not out of compliance.
• It is a rule violation if children are allowed to use equipment unsafely or if a caregiver does not quickly stop an unsafe practice.

Risk Level
Moderate

Corrective Action for 1st Instance
Citation Warning
(2) The provider shall ensure that, when in use, stationary play equipment is not placed on a hard surface such as concrete, asphalt, dirt, or the bare floor.

**Rationale/Explanation**
Head-impact injuries present a significant danger to children. Falls into a shock-absorbing surface are less likely to cause serious injury because the surface is yielding, so peak deceleration and force are reduced. CFOC 4th ed. Standard 6.2.3.1 p.p. 292-293.

**Compliance Guidelines**
- Packed sand and/or dirt (it does not displace when walking on it) is considered a hard surface.
- Acceptable cushioning includes grass, artificial grass, woodchips, unitary cushioning, mats, carpet, sand, shredded tires, and gravel.
- Mats used for cushioning must be in place under and around play equipment when children use the equipment. If cushioning mats are removed when there are no children in the area, CCL staff may ask to see how the mats are placed before children use the play equipment.
- Cushioning material that is frozen is considered a hard surface. If the cushioning cannot be loosened due to weather conditions, children may not use the play equipment until the material can be loosened. Although the equipment does not need to be inaccessible, it is a rule violation if children use the equipment while the cushioning is frozen.

**Risk Level**
Moderate

**Corrective Action for 1st Instance**
Citation Warning

(3) Except for trampolines, the provider shall ensure that stationary play equipment with a designated play surface that is 18 inches high or higher:

- (a) has a surrounding three-foot use zone, free of hard objects or surfaces, that extends from the outermost edge of the equipment;
- (b) has cushioning that covers the entire required use zone; and
- (c) is stable or securely anchored.

**Rationale/Explanation**
Use zones allow for unrestricted movement around the equipment. Prevention of accidents is highly increased when use zones are free of any hard surfaces or objects since children using the equipment may inadvertently fall or jump from the equipment.

**Compliance Guidelines**
- When the use zone for play equipment is measured:
  - Each piece of play equipment must be placed where it is normally used by the children.
  - Measurements will be taken from the play equipment's outermost edge extending in all directions around and above the equipment.
  - A ½ inch allowance will be given to account for any uneven ground surfaces.
- Mats that are a component of foam climbers are considered cushioning and part of the use
• A third supporting leg that is used to help stabilize the play equipment and extends beyond
the equipment frame is not considered when determining the required use zone.
• Tunnels — If a tunnel is used to climb on, then the tunnel must be in compliance with this rule. If
the tunnel is used only as a tunnel to crawl through or if the tunnel is less than 18 inches high,
then a use zone and cushioning are not required.
• Stumps, disks, or pillars — If they are meant for stepping from one to the other, they are
considered one piece of equipment even though they are installed individually. If they are 18
inches or higher, a use zone is required around the group of stumps, disks, or pillars, and not
around each individual component.
• Climbing wall — The highest designated play surface on a climbing wall is the highest flat 2 inch
by 2 inch surface or the highest hand hold.
• Other equipment — Examples of other stationary play equipment that may require a use zone
are listed in the introduction of this section.

A use zone is not required for:
• Stumps, boulders, disks, or pillars that are only used as seating.
• Portable stumps that children can move around.
• Sand diggers.
• Spring rockers and rocking horses that are less than 18 inches high.
• A playhouse with an attached slide that is blocked so that children cannot use the slide
• Areas above the roof of a piece of play equipment.
• The back or side of a piece of equipment that is flush against a wall.
• An embankment slide except at the bottom of the slide chute. This use zone must be at least
as wide as the slide chute.
• Tetherball poles.

Risk Level
Moderate
Corrective Action for 1st Instance
Citation Warning

(4) The department may consider a trampoline on the premises to be inaccessible to children
in care if the trampoline:
   (a) is enclosed behind a locked fence or safety net that is at least three feet high;
   (b) has no jumping mat; or
   (c) is placed upside down.

Rationale / Explanation
The AAP recommends: “Despite all currently available measures to prevent injury, the potential for
serious injury while using a trampoline remains. The numbers of injuries incurred on trampolines
is large and growing. CFOC 4th ed. Standard 6.2.4.4 p.p. 295.
Licensing rules are based on AAP-recommended safety precautions and apply to any accessible trampoline on the premises, including mini, exercise, and in-the-ground trampolines. The hazards that may result in injuries and deaths are from:

- Falling or jumping off the trampoline.
- Falling on the trampoline springs or frame.
- Colliding with another person on the trampoline.
- Landing improperly while jumping or doing stunts on the trampoline.

**Compliance Guidelines**
- Trampolines that are made inaccessible and not in use by children are not assessed.
- A trampoline may not be in the use zone of another piece of play equipment even if the trampoline is inaccessible.

**Risk Level**
High

**Corrective Action for 1st Instance**
Citation and CMP Warning

(5) The provider shall ensure that each accessible trampoline without a safety net enclosure has at least a six-foot use zone that is measured from the outermost edge of the trampoline frame, and that is free from any structure or object including play equipment, trees, and fences.

**Compliance Guidelines**
- 6-feet are measured from the outermost part of the trampoline.
- A caregiver must actively prevent children from leaving moveable objects (e.g. tricycles, toys, and other hard objects) in a use zone, or quickly remove the objects from the use zone.

(6) The provider shall ensure that each accessible trampoline with a properly installed safety net enclosure, used as specified by the manufacturer, and in good repair has at least a three-foot use zone that is measured from the outermost edge of the trampoline frame, and that is free from any structure or object including play equipment, trees, and fences.

**Risk Level**
High

**Corrective Action for 1st Instance**
Citation and CMP Warning

(7) The provider shall ensure that each accessible trampoline with or without a safety net enclosure is placed over:

(a) grass;
(b) six-inch deep cushioning; or
(c) other commercial cushioning.
(8) The provider shall ensure that cushioning for each accessible trampoline covers the entire required use zone.

(9) The provider shall ensure that each accessible trampoline has:
   (a) no ladders or other objects within the use zone a child could use to climb on the trampoline; and
   (b) shock absorbing pads that completely cover the trampoline springs, hooks, and frame.

Rationale / Explanation
A trampoline pad is one of the most important parts of a trampoline because it is made of high density, shock-absorbent materials. However, over time this material wears out becoming less shock absorbent and needs to be replaced on a regular basis.

Compliance Guidelines
Children may use a ladder or other object to climb on the trampoline as long as 1) an adult is supervising at the trampoline, and 2) the ladder or object is moved out of the use zone while the child is jumping.

(10) The provider shall receive written permission from a child’s parent or legal guardian before that child uses the trampoline.

Rationale / Explanation
It is important that parents understand the risks associated with children jumping on trampolines and acknowledge the safety rules that their children must follow if allowed to use the trampoline.
Corrective Action for 1st Instance
Warning

(11) The provider shall ensure that if a child uses an accessible trampoline:
(a) a caregiver is at the trampoline supervising;
(b) only one person at a time uses the trampoline;
(c) no child in care is allowed to do somersaults or flips on the trampoline;
(d) no one is allowed to be under the trampoline while the trampoline is in use; and
(e) only school-age children in care are allowed to use a trampoline.

Rationale / Explanation
Both the American Academy of Pediatrics (AAP) and American Academy of Orthopedic Surgeons (AAOS) Policy Statements recommend the prohibition of trampolines for children younger than six years of age. The AAP recommends: “Despite all currently available measures to prevent injury, the potential for serious injury while using a trampoline remains. The need for supervision and trained personnel at all times makes home use extremely unwise”. CFOC 4th ed. Standard 6.2.4.4 p.p. 295.

Compliance Guidelines
• Supervision at a trampoline means a caregiver is standing close enough to be able to touch the trampoline.
• It is a rule violation if school-age children are outside by themselves and there is an accessible trampoline.

Risk Level
High
Corrective Action for 1st Instance
Citation and CMP Warning

(12) The provider shall ensure that there are no entrapment hazards on or within the use zone of any piece of stationary play equipment.

Rationale/Explanation
All openings in pieces of play equipment should be designed too large for a child's head to get stuck in or too small for a child's body to fit into, in order to prevent entrapment and strangulation. Any equipment opening between three and one-half inches and nine inches in diameter presents the potential for head entrapment. Similarly, openings between three-eighths inch and one inch can cause entrapment of the child's fingers. CFOC 4th ed. Standard 6.2.1.9 p.p. 290.

Compliance Guidelines
• This rule only applies to entrapment hazards where a child's feet cannot touch the floor, ground, or designated play surface (with the exception of ladders).
• On play equipment ladders, there shall be no entrapment hazards where a child's feet cannot
touch the floor or ground.
• An opening directly under a platform and higher than 48 inches from any surface a child could climb on will not be considered an entrapment hazard.

To determine compliance with this rule:
• Measure from the floor or ground (or other play surface) to the bottom of the opening to determine whether a child's feet could touch the ground. A child's feet could not touch the ground if:
  - For infants or toddlers: the bottom of the opening is higher than 23¼ inches above the ground.
  - For preschoolers: the bottom of the opening is higher than 25¼ inches above the ground.
  - For school-age children: the bottom of the opening is higher than 33 inches above the ground.
• If the stationary play equipment is used by children of different age groups, refer to the measurement that applies to the youngest children who are allowed to use the equipment.
• If the opening is at a height where a child's feet could not touch the ground, measure the size of the opening to determine if it is an entrapment hazard.

Risk Level
High
Corrective Action for 1st Instance
Citation and CMP Warning

(13) The provider shall ensure that there are no strangulation hazards on or within the use zone of any piece of stationary play equipment.

Rationale/Explanation
A strangulation hazard is something on which a child's clothes or drawstrings could become caught, or something in which a child could become entangled.

Strangulation is the leading cause of playground fatalities. Some of these deaths occur when drawstrings on sweatshirts, coats, and other clothing get caught in gaps in the equipment. The area on top of slides is one potential trouble spot. CFOC 4th ed. Appendix EE. p.p. 534.

Compliance Guidelines
• Strangulation hazards are typically caused by 1) hardware or small equipment components that protrude out from a surface, 2) hardware that forms a hook or leaves a gap or space between components, and 3) hanging ropes, cords, wire, or chains that are long enough to encircle a child's neck.
• Since the use zone surrounds the play equipment, including the area above the equipment, there cannot be tree branches or another object that creates a strangulation hazard in the use zone above the equipment.

Protrusions

Section 19 - Play Equipment
Strangulation hazards caused by protrusions include:
• Bolt ends that extend more than two threads beyond the face of the nut unless the bolt end is facing straight down.
• A bolt, screw, or other protrusion which increases in size or diameter as it moves away from the surface (e.g. a bolt with a large bolt head that is not flush with the surface).
• A bolt, screw, or other protrusion angled upward from a horizontal plane that fails the protrusion gauge test.
• Loose handholds on climbing walls.

To assess protruding elements on pieces of playground equipment a licensor will use gauges designed for inspecting playground equipment.

Gaps or Openings
Strangulation hazards caused by hardware gaps or space between components include:
• A hardware connector, such as an S- or C-hook, that has a gap or opening greater than .04 of an inch (the edge of a dime) and the opening does not face downward.

To assess gaps on play equipment:
• All connectors such as S- and C-hooks must be checked, no matter where they are located on a piece of equipment, except those that are:
  - At the top of a free standing swing higher than 8 feet.
  - At the top of a swing with a crossbar that is higher than 8 feet.
• Use a dime or the wire hook tool to measure the width of the gap or space.
  - When the dime or tool does not fit in the gap, it is not a strangulation hazard.
  - When the dime or wire tool fits into the gap and the gap angles upward, it is a strangulation hazard.
• CCL does not assess gaps at the top of slide chutes.

Hanging Ropes, Cords, Chains
Strangulation hazards caused by ropes, cords, chains, etc. include:
• Hanging ropes, cords, wires, or chains that are 12 inches or longer and can make a loop 5 inches in diameter, except ropes, cords, wires, or chains with swings or tetherballs attached to the bottoms of them.
• Ropes, cords, twine, etc. that hang into the use zone of a piece of playground equipment and are attached to something solid.

To assess ropes, cords, chains, twine, etc. for possible strangulation hazards:
• Measure the rope, cord, or chain to determine if it is 12 inches or longer.
• Determine if it can make a loop that is 5 inches in diameter.
  - When the rope is not 12 inches or longer and cannot make a 5-inch loop, it is not a strangulation hazard.
  - When the rope is 12 inches or longer and can make a 5-inch loop, it is a strangulation hazard.
hazard if attached to a solid structure or other object.
The following equipment components are not out of compliance:
• Protrusion or strangulation hazards on the underside of platforms that are 48 inches or higher.
• Protrusions on the top crossbar of free standing swings when the top of the swing is higher than 8 feet tall and there is not a horizontal bar between the support poles, nor is the swing attached to any other component or platform.
• Protruding parts that are molded as a part of the design for dramatic play, such as the eyepiece of a telescope or the ear of an animal (as long as the part is in good repair and no parts are missing).
• Handholds and foot bars that are designed for that purpose, such as those found on spring rockers.
• A bolt end or other protruding hardware in recessed areas unless it extends past the recessed area.
• Ropes or cords suspending a tetherball or swing.

Risk Level
High

Corrective Action for 1st Instance
Citation and CMP Warning

(14) The provider shall ensure that there are no crush, shearing, or sharp edge hazards on or within the use zone of any piece of stationary play equipment.

Rationale/Explanations
Playground injuries often involve pinching, catching, or crushing of body parts or clothing by equipment mechanisms. CFOC 4th ed. Standard 6.2.1.7 p.p. 290.

Anything that could crush or shear limbs should not be accessible to children on a playground. Crush and shear points can be caused by parts moving relative to each other or to a fixed part during a normal use cycle, such as a seesaw. CPSC Standard 3.1 p.p. 14.

Any sharp or protruding surface presents a potential for lacerations and contusions to the child’s body. CFOC 4th ed. Standard 6.2.1.8 p.p. 290.

Compliance Guidelines
For crush hazards, it is a rule violation if:
• A disc swing hanging from a tree or frame touches the trunk of the tree or the frame when the swing is stretched to its full length.
• Two moving parts on a piece of equipment come together is such a way that they could crush a child’s fingers, toes, or other body part.

For shearing hazards, it is a rule violation if:
• There are two pieces of equipment or two parts of a piece of equipment that move against each other in such a way that they could sever a child’s fingers, toes, or other body parts.
For sharp edge hazards, it is a rule violation if:
• There is a sharp point or edge that could cut or puncture a child's skin on a piece of equipment's play surface or in a use zone. This includes any play surface that the children usually come in contact with, for example, a platform, an equipment part commonly touched by the children, the hand rail on a slide, the slide surface, etc.

Additional guidelines:
• Since the use zone surrounds the play equipment, including above the equipment, there cannot be hard or inflexible tree branches or any other object that creates a crush, shearing, or sharp edge hazard in the use zone above the equipment.
• A molded plastic steering wheel that is part of a piece of play equipment will not be assessed as a crush hazard.
• It is not out of compliance when the movement between two pieces of equipment or two parts of a piece of equipment is minimal and would be unlikely to cause contusions, lacerations, abrasions, amputations, or fractures during use.

Risk Level
High
Corrective Action for 1st Instance
Citation and CMP Warning

(15) The provider shall ensure that there are no tripping hazards such as concrete footings, tree stumps, tree roots, or rocks within the use zone of any piece of stationary play equipment.

Rationale/Explanation
Tripping is one of the hazards listed by CPSC to be most commonly associated with injury. CFOC 4th ed. Standard 5.3.1.1 p.p. 237-238.

Compliance Guidelines
In addition to those listed in rule, other tripping hazards include:
• Weed barrier that is pulled up.
• An object such as a tire used to cushion an equipment footing unless the object is flush to the ground.
• The leash or rope of a tethered animal if it can reach into the use zone of a piece of play equipment.
• Metal rods in horseshoe pits that are in the use zone of outdoor play equipment.
• Equipment frames or supports that are not part of the original equipment or are not directly under a platform.

The following are not considered tripping hazards:
• Mats that are placed under equipment as cushioning.
• Poles on a tent-type sandbox or canopy unless the poles are in the use zone of another piece of equipment.
• Equipment frames or supports that are part of the original equipment or are directly under a platform.
• Moveable objects (e.g. tricycles, toys, and other hard objects) that are left in the use zone of stationary play equipment when the equipment is not being used.
• Moveable objects that are left in a use zone by children, but are immediately removed from the area.

Risk Level
Moderate

Corrective Action for 1st Instance
Citation Warning
The rules and information in this section apply when a provider walks, transports, and/or uses public transportation to accompany a child in care from one place to another. A provider’s policies on offering transportation should comply with the requirements of the American with Disabilities Act (ADA). For more information about this law, refer to: www.ada.gov.

When the provider arranges and is responsible for a child to be taken to or from the facility for any reason, the provider must be in compliance with licensing rules. For example, if the provider asks a parent to be an additional driver on a field trip, then all applicable licensing rules are in effect for the parent (such as passing a background check) as well as for the vehicle the parent is driving.

However, when a parent arranges and is responsible for their own child to be taken to or from the facility, then licensing rules do not apply while the child is under the responsibility of someone other than the provider. For example, if parents arrange to carpool their children to and from school without the provider’s involvement, then licensing rules do not apply during carpooling.

If transportation services are offered:

(1) For each child being transported, the provider shall have a transportation permission form:
   (a) signed by the parent; and
   (b) on-site for review by the department

Rationale/Explanation
When a child is being transported the potential risk of injury increases. For a child’s health and safety, it is important that the child’s parents understand and give permission for when, where, why, and how their child will be transported.

Compliance Guidelines
• This rule is out of compliance when the provider does not have a record of signed permission by the parent available at the facility for review.
• This permission form may be either hardcopy or electronic.
• Digital signatures are acceptable.
• The provider does not need to take the permission form offsite with them.

Risk Level
Moderate

Corrective Action for 1st Instance
Citation Warning

(2) The provider shall ensure that each vehicle used for transporting children:
   (a) is enclosed with a roof or top;
is equipped with safety restraints;
(c) has a current vehicle registration;
(d) is maintained in a safe and clean condition; and
(e) contains first aid supplies, including at least antiseptic, bandages, and tweezers.

Rationale/Explanation
The use of child safety seats reduces risk of death by 71% for children less than one year of age and by 54% for children ages one to four. In addition, booster seats reduce the risk of injury in a crash by 45%, compared to the use of an adult seat belt alone. CFOC 4th ed. Standard 6.5.2.2 p.p. 311.

Motor vehicle crashes are the leading cause of death in children two to fourteen years of age in the United States. It is necessary for the safety of children to require that the caregiver/teacher comply with requirements governing the transportation of children in care, in the absence of the parent/guardian. Not all vehicles are designed to safely transport children, especially young children. CFOC 4th ed. Standard 9.2.5.1 p.p. 402-403.

The facility should maintain first aid and emergency supplies in each location where children are cared for. CFOC 4th ed. Standard 5.6.0.1 p.p. 274-275.

Compliance Guidelines
• This rule applies to each vehicle that is used to transport children in care.
• "Safety restraints" refers to seat belts, car seats, and booster seats. They must be used individually, and as required by Utah law.
• A current registration is verified by the sticker on the license plate or a current registration certificate.
• Vehicle windows should be clean enough that a driver has adequate visibility to drive safely.
• The rule does not require that the vehicle windows be rolled up.
• The vehicle's interior can show signs of normal use and does not have to be entirely free of all debris. This rule applies to situations in which a buildup of dirt or debris could endanger children's health or safety. For example, a pile of debris could cause a child to trip, or rotting food could provide a place where disease-causing bacteria can grow.

Risk Level
Moderate

Corrective Action for 1st Instance
Citation Warning

(3) The provider shall ensure that the safety restraints in each vehicle that transports children are:
   (a) appropriate for the age and size of each child who is transported, as required by Utah law;
   (b) properly installed; and
   (c) in safe condition and working order
Rationale/Explanation
The best car safety seat is one that fits in the vehicle being used, fits the child being transported, has never been in a crash, and is used correctly every time. The use of restraint devices while riding in a vehicle reduces the likelihood of any passenger suffering serious injury or death if the vehicle is involved in a crash CFOC 4th ed. Standard 6.5.2.2 p.p. 310-311.

For a safety restraint to be effective in preventing injury or death in a vehicle accident, the restraint must be age and size appropriate, installed according to manufacturer’s instructions, and in working condition.
• Child restraint laws vary by state. For up-to-date information on Utah’s laws, check with the Insurance Institute for Highway Safety at www.iihs.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 seatcheck.org.

Compliance Guidelines
• Safety restraints (seat belts, car seats, and booster seats) must be securely installed during transportation.
• Safety restraints are considered in safe condition and working order when they are not broken, frayed, or torn, and their locks work properly.
• Car seats typically expire after six years. Providers must check the manufacturer sticker to ensure the seat is still in safe working condition.

Risk Level
Moderate
Corrective Action for 1st Instance
Citation Warning

(4) The provider shall ensure that the driver of each vehicle who is transporting children:
(a) is at least 18 years old;
(b) has and carries with them a current, valid driver’s license for the type of vehicle being driven;
(c) has with them the written emergency contact information for each child being transported;
(d) ensures that each child being transported is in an individual safety restraint that is used according to Utah law;
(e) ensures that the inside vehicle temperature is between 60-85 degrees Fahrenheit;
(f) never leaves a child in the vehicle unattended by an adult;
(g) ensures that children stay seated while the vehicle is moving;
(h) never leaves the keys in the ignition when not in the driver’s seat; and
(i) ensures that the vehicle is locked during transport

Rationale/Explanation
Driver Qualifications
Driving children is a significant responsibility. Child care programs must assure that anyone who drives the children is competent to drive the vehicle being driven. CFOC 4th ed. Standard 6.5.1.2 p.p. 309.

In Utah, a person who drives a vehicle designed to carry 16 or more passengers including the driver, is required to have a commercial driver's license (CDL). See Utah Code 53-3-412.

Emergency Contact Information
In the event of an accident or a missing child, both caregivers and emergency response personnel need access to the children's emergency and contact information. CFOC 4th ed. Standard 9.2.4.1 p.p. 393-394.

Safety Restraints
"Safety restraints" refers to seat belts, car seats, and booster seats.

Utah Code 41-6a-1803 states the following regarding the use of child restraints:
(1)(a) The operator of a motor vehicle operated on a highway shall:
   (i) wear a properly adjusted and fastened safety belt;
   (ii) provide for the protection of each person younger than eight years of age by using a child restraint device to restrain each person in the manner prescribed by the manufacturer of the device; and
   (iii) provide for the protection of each person eight years of age up to 16 years of age by securing, or causing to be secured, a properly adjusted and fastened safety belt on each person.

Vehicle Temperature
The interior of vehicles used to transport children should be maintained at a temperature comfortable to children. Some children have problems with temperature variations. Whenever possible, opening windows to provide fresh air to cool a hot interior is preferable before using air conditioning. Over-use of air conditioning can increase problems with respiratory infections and allergies. Excessively high temperatures in vehicles can cause neurological damage in children. CFOC 4th ed. Standard 6.5.2.4 p.p. 312.

The American Academy of Pediatrics and the American Public Health Association recommend:
• The inside temperature of the vehicle should be maintained at a temperature comfortable to children.
• When the vehicle's interior temperature exceeds 82 degrees Fahrenheit and opening the windows does not reduce the temperature, the vehicle should be air conditioned. Temperatures in hot cars can reach dangerous levels within 15 minutes.
• When the interior temperature drops below 65 degrees Fahrenheit and when children are feeling uncomfortably cold, the interior should be heated. CFOC 4th ed. Standard 6.5.2.4 p.p. 313.

Supervision
Children have died from heat stress from being left unattended in closed vehicles. Temperatures in hot motor vehicles can reach dangerous levels within fifteen minutes. Due to this danger, vehicles should be locked when not in use and checked after use to make sure no child is left unintentionally in a vehicle. Children left unattended also can be victims of backovers (when an unseen child is run over by being behind a vehicle that is backing up), power window strangulations, and other preventable injuries. CFOC 4th ed. Standard 6.5.1.1 p.p. 307-308.

To prevent hyperthermia, all vehicles should be locked when not in use, head counts of children should be taken after transporting to prevent a child from being left unintentionally in a vehicle, and children should never be intentionally left in a vehicle unattended. CFOC 4th ed. Standard 6.5.2.4 p.p. 312.

Compliance Guidelines
• The driver must have a paper copy of children’s contact and emergency information. Having only an electronic copy could result in critical information being inaccessible to emergency personnel and others who may need it in the event of an accident.
• When loading and unloading children into a vehicle, the driver may not leave one child unattended in a vehicle while going inside the facility to take or get another child.
• When children are in a vehicle, the driver may walk around the vehicle to attend to children (e.g. buckling belts) as long as the vehicle is not running and the keys are not in the ignition.
• In the case of keyless cars, the fob cannot be left in the vehicle unless the driver is in the driver’s seat.
• A bus that will not go into drive gear when the bus door is locked is exempt from being locked during transport.
• When the vehicle is colder than 60 degrees fahrenheit the heat must be turned on and when the vehicle is warmer than 85 degrees fahrenheit the air conditioning must be turned on.
• If the temperature cannot be regulated and it is colder than 60 degrees fahrenheit or warmer than 85 degrees fahrenheit in the vehicle during transportation, then the children cannot be transported in the vehicle.
• If a child is left unattended in a vehicle, the violation will be issued to 50-11(1).

Risk Level
High
Corrective Action for 1st Instance
If a child is transported without an individual restraint according to Utah law

Risk Level
Moderate
Corrective Action for 1st Instance
Citation Warning otherwise

(5) If the provider walks or uses public transportation to transport children to or from the facility, the provider shall ensure that:

Section 20 - Transportation
(a) each child being transported has a completed transportation permission form signed by their parent;  
(b) a caregiver goes with the children and actively supervises the children;  
(c) the caregiver-to-child ratio is maintained; and  
(d) a caregiver with the children has written emergency contact information and releases for the children being transported.

Rationale/Explanation
Parents expect that their children will be safe including when offsite. The provider must ensure compliance with all applicable transportation rules when walking or using public transportation to take a child to and from another location. This includes such activities as going to and from school, taking a walk around the neighborhood, and using public transportation.

Compliance Guidelines
• The caregiver who is accompanying the children must have a paper copy of the children's contact and emergency information. The information may not be stored electronically because in the event of an accident, emergency responders may not be able to access needed information.  
• When some children are on an offsite activity and at the same time there are some children at the facility, the provider must maintain the caregiver-to-child ratio and supervision for each group.  
• “Releases” refers to each child's current emergency medical treatment and emergency transportation releases (with the parent's signature) that are required as part of the child admission and health assessment information.  
• Having a copy of the child's written emergency contact information and releases (rather than the original) meets the intent of this rule.

Risk Level
High
Corrective Action for 1st Instance
• For lack of supervision, the corrective action will be issued to rule 50-11(1).  
• When the caregiver-to-child ratio is out of compliance, the corrective action will be issued to 50-10(1).

Risk Level
Moderate
Corrective Action for 1st Instance
Citation Warning otherwise
Animals

This section consists of the rules and supporting information pertaining to animals that are in a child care setting. The rules apply if any animals are regularly allowed on the premises whether or not the animals belong to the provider.

The risk of injury, infection, and aggravation of allergy from contact between children and animals is significant. The staff must plan carefully when having an animal in the facility and when visiting a zoo or local pet store (5,9,10). Children should be brought into direct contact only with animals known to be friendly and comfortable in the company of children. CFOC 4th ed. Standard 3.4.2.1 p.p. 129.

(1) The provider shall inform parents of the kinds of animals allowed at the facility.

**Rationale/Explanation**

Bringing animals and children together has both risks and benefits. Animals teach children about how to be gentle and responsible, about life and death, and about unconditional love. Nevertheless, animals can pose serious health and safety risks. CFOC 4th ed. Standard 3.4.2.1 p.p. 129.

**Compliance Guidelines**

The provider must inform parents of animals that are on the premises on a regular basis even when the animal does not reside at the facility. For example, if the provider chooses to feed a stray animal or takes care of any animal at the facility, the provider must notify parents of the animal's presence.

**Risk Level**

Low

**Corrective Action for 1st Instance**

Warning

(2) The provider shall ensure that there is no animal on the premises that:

(a) is naturally aggressive;
(b) has a history of dangerous, attacking, or aggressive behavior; or
(c) has a history of biting even one individual.

**Rationale/Explanation**

The risk of injury, infection, and aggravation of allergy from contact between children and animals is significant. The staff must plan carefully when having an animal in the facility and when visiting a zoo or local pet store. Children should be brought into direct contact only with animals known to be friendly and comfortable in the company of children. Dog bites to children under four years of age usually occur at home, and the most common injury sites are the head, face, and neck. Many
human illnesses can be acquired from animals. Many allergic children have symptoms when they are around animals. CFOC 4thed. Standard 3.4.2.1 p.p. 129.

**Compliance Guidelines**

- Aggressive animals are animals which are bred or trained to demonstrate aggression towards humans or other animals, or animals which have demonstrated such aggressive behavior in the past and animals that have bitten a person, may not be permitted on the premises of the child care facility whether or not they are kept in a cage, and whether or not they are vaccinated.
- Boa constrictors, anacondas, and most pythons are examples of naturally aggressive snakes and are very dangerous. They may not be on the premises.
- Contact between animals and children should be supervised by a caregiver who is close enough to remove the child immediately if the animal shows signs of distress (e.g., growling, baring teeth, tail down, ears back) or the child shows signs of treating the animal inappropriately.

**Risk Level**

High

**Corrective Action for 1st Instance**

Citation and CMP Warning

(3) The provider shall ensure that animals at the facility are clean and free of obvious disease or health problems that could adversely affect children.

**Rationale/Explanation**

Animals, including pets, are a source of illness for people, and people may be a source of illness for animals. Reptiles usually carry salmonella and pose a risk to children who are likely to put unwashed hands in their mouths. CFOC 4th ed. Standard 3.4.2.3 p.p. 130.

Animals can be entertaining and educational. But children, especially children under 5 years of age, are more likely to get sick from germs animals can sometimes carry. Children can learn a lot from animals, and it's important to make sure they stay safe and healthy while they're learning. If you plan to have an animal in your classroom, whether it's a class pet or for a hands-on learning experience, be aware of the risks and how to prevent illness. You can help kids enjoy and learn from animals while staying healthy. Visit CDC: Animals in Schools and Daycares for more information.

**Compliance Guidelines**

- Animals accessible to children should not be visibly dirty.
- Animals who are ill should be kept separate from children in care.

**Risk Level**

Low

**Corrective Action for 1st Instance**

Warning
(4) The provider shall ensure that there is no animal or animal equipment in food preparation or eating areas.

Rationale/Explanation
The food preparation area of the kitchen should be separate from eating, play, laundry, toilet, and bathroom areas and from areas where animals are permitted. CFOC 4th ed. Standard 4.8.0.1 p.p. 197.

Compliance Guidelines
• Animals and their equipment, such as food and water bowls, cat litter boxes, or dog beds, cannot be within 36 inches of food preparation or eating areas. All kitchen counters are considered to be food preparation areas.
• To determine if there is adequate space between animal equipment and food preparation and eating areas, a measurement is taken from the outermost edge of the food preparation or eating area to the outermost part of the animal equipment.
• This rule does not prohibit fish bowls or tanks in food preparation or eating areas. However, these habitats need to be well maintained because fish and their aquariums may carry germs.
• This rule does not prohibit animals from being in the food preparation or eating areas while food preparation or eating are not taking place.

Risk Level
Low
Corrective Action for 1st Instance
Warning

(5) The provider shall ensure that children younger than five years old do not assist with the cleaning of animals or animal cages, pens, or equipment.

Rationale/Explanation
Children and food handlers should not handle or clean up any form of animal waste (feces, urine, blood, etc). All animal waste and litter should be removed immediately from children's areas and will be disposed of in a way where children cannot come in contact with the material. CFOC 4th ed. Standard 3.4.2.3 p.p. 130.

Risk Level
Low
Corrective Action for 1st Instance
Warning

(6) If school-age children help in the cleaning of animals or animal equipment, the provider shall ensure that the children wash their hands immediately after cleaning the animal or equipment.
Rationale/Explanation
The AAP and APHA suggest that caregivers instruct children on safe procedures to follow when cleaning animals or their equipment including:
- Use disposable gloves when cleaning animal equipment.
- Do not let children clean aquariums because contaminated water can splash into eyes and mouths.
- Do not dispose of used fish tank water in sinks used for getting drinking water or food preparation.
- Remove all animal waste and litter immediately from children's areas.
- Disinfect areas where equipment is cleaned after the cleaning activity is finished.
CFOC 4th ed. Standard 3.4.2.3 p.p. 130.

Risk Level
Moderate
Corrective Action for 1st Instance
Citation Warning

(7) The provider shall ensure that children and staff wash their hands immediately after playing with or touching reptiles and amphibians.

Rationale/Explanation
Reptiles and amphibians are species known to carry salmonella. All persons who have contact with animals, animal products, or animal environments should wash their hands immediately after the contact. CFOC 4th ed. Standard 3.4.2.3 p.p. 131

Risk Level
Moderate
Corrective Action for 1st Instance
Citation Warning

(8) The provider shall ensure that dogs, cats, and ferrets that are housed at the facility have current rabies vaccinations.

Rationale/Explanation
Although the spread of diseases from animals to people is rare, pets do sometimes carry germs that can make people sick. Learn about the germs that animals in your facility can spread plus actions you can take that can help you and your pets stay healthy at CDC: Pets and Other Animals.

Compliance Guidelines
This rule applies to dogs, cats, and ferrets that are repeatedly (more than one time) on the premises whether or not they belong to the provider. For example, if the provider takes care of an animal at the facility or chooses to feed a stray animal, that animal must have current rabies vaccinations.
(9) The provider shall keep current animal vaccination records on-site for review by the department.

**Rationale/Explanation**
Vaccination records help the provider track and keep their animal's vaccinations current as well as provide proof that the provider is in compliance with licensing rule.

**Compliance Guidelines**
- An animal's veterinary tag is acceptable documentation as long as it has enough information to show that the animal's vaccinations are current.
- The provider does not need immunization records for animals that are brought in for show and tell.

**Risk Level**
Low

**Corrective Action for 1st Instance**
Warning
This section explains the rules regarding children’s rest and sleep in a child care program. The section also explains the rules that apply to sleeping equipment used by children in care. This includes sleeping equipment that is used during child care hours by the provider’s and caregivers’ own children younger than 4 years old.

**Rest and Sleep**

(1) The provider shall offer children in care a daily opportunity for rest or sleep in an environment with subdued lighting, a low noise level, and freedom from distractions.

**Rationale/Explanation**
Studies suggest that sleep is essential for the optimal health and growth of children. The Centers for Disease Control and Prevention (CDC) makes the following recommendations.

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Recommended Hours of Sleep Per Day</th>
</tr>
</thead>
<tbody>
<tr>
<td>Newborn: 0-3 months</td>
<td>14-17 hours</td>
</tr>
<tr>
<td>Infant: 4-12 months</td>
<td>12-16 hours</td>
</tr>
<tr>
<td>Toddlers: 1-2 years</td>
<td>11-14 hours</td>
</tr>
<tr>
<td>Preschool: 3-5 years</td>
<td>10-13 hours</td>
</tr>
<tr>
<td>School Age: 6-12 years</td>
<td>9-12 hours</td>
</tr>
<tr>
<td>Teen: 13-18 years</td>
<td>8-10 hours</td>
</tr>
</tbody>
</table>

Conditions conducive to sleep and rest for younger children include a consistent caregiver, a routine quiet place, regular times for rest, and use of routines and safe practices. Most preschool-aged children in all-day care benefit from scheduled periods of rest. This rest may take the form of actual napping, a quiet time, or a change of pace between activities. The times and duration of naps will affect behavior at home. CFOC 4th ed. Standard 3.1.4.4 p.p. 106.

According to the CDC, children who do not get enough sleep are more likely to:
• Be overweight.
• Not get enough physical activity.
• Suffer from depressive symptoms.
• Engage in unhealthy risk behaviors such as drinking alcohol.
Perform poorly in school.

**Compliance Guidelines**
Children who do not nap must be given an opportunity to rest by doing a quiet activity such as reading, coloring, puzzles, mindfulness or another calm activity during the day.

**Risk Level**
Low

**Corrective Action for 1st Instance**
Warning

(2) The provider shall ensure that each crib:
   (a) has a tight-fitting mattress;
   (b) has slats spaced no more than 2-3/8 inches apart;
   (c) has at least 20 inches from the top of the mattress to the top of the crib rail, or at least 12 inches from the top of the mattress to the top of the crib rail if the child using the crib cannot sit up without assistance;
   (d) does not have strings, cords, ropes, or other entanglement hazards on the crib or within reach of the child; and
   (e) has documentation from the manufacturer or retailer stating that the crib was built after June 28, 2011, or that the crib is certified if the crib was manufactured before that date.

**Rationale/Explanation**
Caregivers/teachers should never use strings to hang any object, such as a mobile, or a toy or a diaper bag, on or near the crib where a child could become caught in it and strangle. Infant monitors and their cords and other electrical cords should never be placed in the crib or sleeping equipment. Crib mattresses should fit snugly and be made specifically for the size crib in which they are placed. Infants should not be placed on an inflatable mattress due to potential of entrapment or suffocation CFOC 4th ed. Standard 5.4.5.1 p.p. 270.

More infants die every year in incidents involving cribs than with any other nursery product. Standards have been developed to define crib safety, and providers should make sure that cribs used in the facility meet these standards to protect children and prevent injuries or death. Significant changes to the ATSM and CPSC standards for cribs took effect as of June 28, 2011. For information about CPSC recommendations visit “Safe Sleep - Cribs and Infants Products Information Center”.

**Compliance Guidelines**

**Tight-fitting mattress**

- To determine if a crib has a tight-fitting mattress
  - Move the mattress to one corner of the crib and as close as possible to the head or foot of the crib.
  - If this creates a gap between the mattress and any side of the crib, place a choke tube (or...
if unavailable, two adult fingers together) vertically at the widest point of each gap. If the tube fits entirely between the crib side and the mattress, the mattress is not tight fitting.

- A firm material such as wood may be added to a crib frame to create a tight-fitting mattress, as long as the material is flush with the top of the mattress.
- It is a rule violation if any item such as a blanket, eggshell mattress, or foam is wedged between the mattress and the crib frame.
- This rule applies only to cribs, not to bassinets, porta-cribs, or playpens.

**Height of crib rail from mattress**

- The rule is out of compliance if:
  - One end of a mattress is propped up making the distance between that end of the mattress and the top of the crib railing less than 20 inches.
  - A hinged crib side is folded down and not in the up position resulting in a measurement that is less than 20 inches from the mattress to the top of the crib side. It is out of compliance even if a caregiver is next to the crib.

**Entanglement Hazards**

- No strings, cords, ropes, or other entanglement or strangulation hazards must be on or in the crib, or within 36 inches of any part of the crib.
- It is a rule violation if any strings or cords are longer than 8 inches and are in or on the sleeping equipment, or within 36 inches from the surface of the sleeping equipment. This includes pacifier cords, mobiles hanging over a crib, and electrical cords that might be on furniture or the floor next to the crib.

**Manufacturing Date**

- To ensure the crib was built after June 28, 2011:
  - Look at the manufacturing date on the crib or the registration form that may have been supplied when the crib was purchased.
  - The manufacturing date can be found usually on the board that holds the mattress or on the lower part of the crib frame.
  - A purchase receipt is not adequate documentation.
  - Confirm that the label or form shows the crib was manufactured on or after June 28, 2011.
- Verify that the crib is not on the [CPSC Recall List](#).
- If a provider believes the crib meets federal standards but does not have a manufacturing date or registration form, the provider may:
  - Contact the manufacturer or retailer and ask for documentation that the crib is in compliance with 16 CFR Part 1219 or 16 CFR Part 1220.
  - Submit the documentation to CCL before using the crib to sleep children in care.

**Risk Level**

Moderate

**Corrective Action for 1st Instance**

Citation Warning
(3) The provider shall ensure that sleeping equipment does not block exits.

**Rationale/Explanation**
Unobstructed access to exits is essential to prompt evacuation. CFOC 4th ed. Standard 5.1.4.3 p.p. 220.

**Compliance Guidelines**
- Sleeping equipment may be placed in front of a door or opening to a room, as long as there is at least one other doorway from the room that is not blocked and could be used in an emergency.
- Sleeping equipment may not block exits even when it is low and can be stepped over.
- Sleeping equipment must be far enough away from a door that if the door were to open inward, there would be enough clearance for the door to fully open (or swing 180 degrees).

**Risk Level**
Moderate

**Corrective Action for 1st Instance**
Citation Warning

(4) The provider shall ensure that sleeping equipment and bedding items are:
   (a) clearly assigned to one child; and
   (b) laundered as needed, but at least once a week, and before use by another child.

**Rationale/Explanation**
No child should sleep on a bare, uncovered surface. Seasonally appropriate covering, such as sheets, sleep garments, or blankets that are sufficient to maintain adequate warmth, should be available and should be used by each child below school-age. Pillows, blankets, and sleep positioners should not be used with infants. If pillows are used by toddlers and older children, pillows should have removable cases that can be laundered, be assigned to a child, and used by that child only while s/he is enrolled in the facility. (Pillows are not required for older children.) Each child’s pillow, blanket, sheet, and any special sleep item should be stored separately from those of other children. CFOC 4th ed. Standard 5.4.5.1 p.p. 268-269.

Scabies and ringworm are diseases transmitted by direct person-to-person contact. For example, ringworm is transmitted by the sharing of personal articles such as combs, brushes, towels, clothing, and bedding. Prohibiting the sharing of personal articles helps prevent the spread of diseases. CFOC 4th ed. Standard 5.4.5.1 p.p. 269.

**Risk Level**
Moderate

**Corrective Action for 1st Instance**
Citation Warning when equipment is not cleaned and sanitized as needed or at least weekly
Low
Corrective Action for 1st Instance
Warning otherwise

(5) The provider shall clean and sanitize sleeping equipment that is not clearly assigned to and used by an individual child before each use.

Rational
Although children freely interact and can contaminate each other while awake, reducing the transmission of infectious disease agents on large airborne droplets during sleep periods will reduce the dose of such agents to which the child is exposed overall. CFOC 4th ed. Standard 5.4.5.1 p.p. 269.

Compliance Guidelines
• When bedding is stored in a bin, bag, or cubby that is labeled with a child’s name, it is considered assigned to an individual child.
• Mats or cots may be clearly assigned to one child by labeling with each child’s name, by identifying each child’s mat or cot with a number or color code, or by labeling the container where the mats or cots are stored.

Risk Level
Moderate
Corrective Action for 1st Instance
Citation Warning
This section gives the rules and information about diapering children in a child care setting. Diapering rules are designed to protect the health and safety of the children and apply to all diapered children regardless of their ages, including the provider's and caregivers' children. A provider's policies on diapering should comply with the requirements of the American with Disabilities Act (ADA). For more information about this law, refer to: www.ada.gov.

The rules pertain to how often diapered children are changed, the procedures for changing diapers, and the supplies that are used. Diapering rules, as applicable, cover disposable training pants, hybrid diapers, and cloth diapers.

CCL staff will observe a diaper change during an inspection to verify compliance with the rules in this section. When observing the diaper change, they will stand back and out of the child's line of vision in order to help maintain the child's privacy and comfort level while being changed.

When no diapered children are present or awake during the inspection, CCL staff will:
• Document that a diaper change was not observed.
• Observe a diaper change at the next annual inspection.

If the provider accepts children who wear diapers:

(1) The provider shall ensure that each child's diaper is:
   (a) checked at least once every two hours;
   (b) promptly changed if wet or soiled; and
   (c) checked as soon as a sleeping child awakens.

Rationale/Explanation
Diapers should be checked for wetness and feces at least hourly, visually inspected at least every two hours, and whenever the child indicates discomfort or exhibits behavior that suggests a soiled or wet diaper. Diapers should be changed when they are found to be wet or soiled. Frequency and severity of diaper dermatitis is lower when diapers are changed more often, regardless of the type of diaper used CFOC 4th ed. Standard 3.2.1.3 p.p. 112.

Compliance Guidelines
• The rule defines how often diapers are checked, but not how they are checked.
• Caregivers do not have to wake a sleeping child to check a diaper.
• The 2-hour time for checking diapers begins when the child arrives at the facility.

Risk Level
Moderate

Corrective Action for 1st Instance
(2) The provider shall ensure that caregivers do not change children's diapers directly on the floor, in a food preparation or eating area, or on any surface used for another purpose.

Rationale/Explanation
Using diaper changing surfaces for any other purpose increases the likelihood of contamination and spreading of infectious disease agents. CFOC 4th ed. Standard 5.4.2.4 p.p. 266.

Compliance Guidelines
• Diapering areas must be at least 36 inches away from food preparation and eating areas.
• An entire table or counter will be considered one area regardless of its size. Therefore, a table or a counter must not be used for both food preparation or eating and diapering.
• Diapering can be done on the floor, couch, bathroom counter, or other surface as long as it is not directly on that surface. There must be a leakproof, waterproof barrier between the surface and the child being changed. For example, a caregiver may place a leakproof, waterproof changing pad on the floor or counter (except in the kitchen) to change a diaper.
• If a surface is smooth, waterproof and in good repair and has been designated for the purpose of diapering, children's diapers can be changed directly on the surface. The provider can choose how to designate the surface and ensure it is not used for any other purpose.
• Children may be diapered directly on a surface that has been designated as a diapering surface as long as the surface meets the requirement of rule.

Risk Level
Moderate

Corrective Action for 1st Instance
Citation Warning

(3) The provider shall ensure that the diapering surface is smooth, waterproof, and in good repair.

Rationale/Explanation
The purpose of this rule is to ensure that diapering surfaces can be adequately cleaned and sanitized in order to prevent the spread of disease. It is difficult, if not impossible, to sanitize porous surfaces or surfaces with cracks or tears. Even a small crack somewhere on the diapering surface could allow bacteria to grow. CFOC 4th ed. Standard 5.4.2.5 p.p. 267.

Compliance Guidelines
• A diapering surface that is in good repair means that there are no tears, cracks, or holes making the surface difficult to sanitize.
• A diapering pad that is repaired with items such as plastic or duct tape, or vinyl glue (if the glue is waterproof when dry) is acceptable as long as the repair is on the underside of the pad and not on the side where a child is changed.
• It is not out of compliance if there is a small crack on the frame of a changing table or other
surrounding surface as long as the crack is not on the surface where the child is changed.
• Changing a child on an unused diaper does not meet the requirement of this rule.

**Risk Level**
Moderate

**Corrective Action for 1st Instance**
Citation Warning

(4) The provider shall ensure that caregivers clean and sanitize the diapering surface after each diaper change, or use a disposable, waterproof diapering surface that is thrown away after each diaper change.

**Rationale/Explanation**
Many infectious diseases can be prevented through appropriate cleaning and disinfection procedures. CFOC 4th ed. Standard 5.4.2.6 p.p. 267.

**Compliance Guidelines**
• Cleaning and sanitizing instructions described in “Section 15: Health and Infection Control” must be followed.
• A caregiver must clean any visible body fluid from the diapering surface and then sanitize the entire diapering surface according to the instructions on the sanitizing product being used.
• The surface under the pad does not have to be cleaned and sanitized unless it is visibly dirty.
• Any product that comes with manufacturer instructions for use as a sanitizer may be used.
• Hand sanitizers may not be used to sanitize diapering surfaces.
• Disinfecting wipes (not hand wipes) can effectively sanitize a surface if the surface remains wet for the time designated by the manufacturer.
• A stopwatch (or clock, phone, iPad, etc.) can be used to verify that the sanitizer remains visibly wet on the surface for the amount of time listed on the product label. To be in compliance, the time must be within 5 seconds of the manufacturer’s required time. If the product is not left on the surface for the required amount of time, the surface will not be sanitized.
• A caregiver should never diaper a child on a surface that is still wet from being cleaned and sanitized. The surface may air dry or, after the sanitizer has remained on the surface for the required amount of time, it may be wiped dry.
• Even when there is only one child who uses the diapering surface, the surface still must be cleaned and sanitized after each use to prevent bacteria and germs from growing on the surface or spreading to another area.

**Risk Level**
Moderate

**Corrective Action for 1st Instance**
Citation Warning
(5) The provider shall ensure that caregivers who change diapers wash their hands after each diaper change.

**Rationale/Explanation**
Many types of infectious germs may be contained in human waste (urine and feces). Touching a contaminated object or surface may spread illness. Handwashing helps prevent the spread of disease-causing agents. CFOC 4th ed. Standard 3.2.3.4 p.p. 123.

**Compliance Guidelines**
- Caregivers must wash their hands with soap and running water after each diaper change.
- Hand sanitizer does not meet the requirements of this rule and should not be used in place of soap and water.

**Risk Level**
Moderate

**Corrective Action for 1st Instance**
Citation Warning

(6) The provider shall ensure that caregivers place wet and soiled disposable diapers:
   (a) in a container that has a disposable plastic lining and a tight-fitting lid;
   (b) directly in an outdoor garbage container that has a tightfitting lid; or
   (c) in a container that is inaccessible to children.

**Rationale/Explanation**
Separate, plastic-lined waste receptacles that do not require touching with contaminated hands or objects and that children cannot access enclose odors within, and prevent children from coming into contact with body fluids. CFOC 4th ed. Standard 5.2.7.4 p.p. 240.

**Compliance Guidelines**
- Flip top or swinging lids on diaper containers are acceptable.
- Diapers may be placed in any container, for example a plastic bag, as long as the container is inaccessible to children.
- Providers may diaper several children, one right after the other, and then properly dispose of all the diapers at the same time. However, handwashing must be done after each diaper change.
- Hybrid diapers are part disposable and part reusable. Caregivers should not flush the insert, but treat it the same as a disposable diaper and properly discard it as described in this rule. The outside cover of the hybrid diaper should be treated as a cloth diaper.

**Risk Level**
Moderate

**Corrective Action for 1st Instance**
Citation Warning
(7) Each day, the provider shall clean and sanitize indoor containers where wet and soiled diapers are placed.

**Rationale/Explanation**
This standard prevents noxious odors and the spread of disease. CFOC 3rd ed. Standard 5.2.7.5 p.p. 241.

**Compliance Guidelines**
- The inside of the container needs to be cleaned and sanitized as well as the outside parts that a caregiver touches when they dispose of a used diaper.
- If a provider uses a diaper genie according to the manufacturer's instructions, the inside of the container does not need to be cleaned and sanitized daily.

**Risk Level**
Moderate

**Corrective Action for 1st Instance**
Citation Warning

(8) If cloth diapers are used, the provider shall:

(a) not rinse cloth diapers at the facility; and
(b) place cloth diapers directly into a leakproof container that is inaccessible to any child and labeled with the child's name; or
(c) place the cloth diapers in a leakproof diapering service container

**Rationale/Explanation**
Containing and minimizing the handling of soiled diapers so they do not contaminate other surfaces is essential to prevent the spread of infectious disease. Putting stool into a toilet in the child care facility increases the likelihood that other surfaces will be contaminated during the disposal. There is no reason to use the toilet for stool if disposable diapers are being used. CFOC 4th ed. Standard 3.2.1.2 p.p. 112.

**Compliance Guidelines**
- Caregivers may rinse soiled diapers in toilets that are inaccessible to children in care, and/or rinse the cloth diapers after children in care leave for the day
- Caregivers may machine wash and dry cloth diapers at the facility as long as wet or soiled diapers are inaccessible until they are cleaned.
- A caregiver may flush the content of a soiled diaper in the toilet before placing the diaper in the leakproof container.
- Plastic grocery and other plastic bags may be used to contain cloth diapers as long as the bags are leakproof. Grocery or other plastic bags with holes in the bottoms or sides cannot be used because they are not leakproof.
- The container does not need to be labeled if put into a child's labeled diaper bag or cubby as long as the diaper bag or cubby is inaccessible.
- If a provider only cares for children from one family, they are not required to label the
leakproof container holding the used cloth diaper, but it must be inaccessible.
• It is not out of compliance for the caregiver to throw away wet or soiled cloth diapers with parental permission.

Risk Level
Moderate

Corrective Action for 1st Instance
Citation Warning
This section provides the rules and information about caring for children ages birth through 23 months. The rules apply to all infants and toddlers in care including the provider's and employees' own children. A child who is younger than 12 months of age is considered an infant. On the child's first birthday and until their second birthday, the child is considered a toddler.

If the provider cares for infants or toddlers:
(1) The provider shall ensure that each awake infant and toddler receives positive physical and verbal interaction with a caregiver at least once every 20 minutes.

Rationale/Explanation
Caregivers/teachers should provide consistent, continuous and inviting opportunities to talk, listen to, and otherwise interact with young infants throughout the day (indoors and outdoors) including feeding, changing, playing with, and cuddling them. CFOC 4th ed. Standard 2.1.2.1, 2.1.2.2 p.p. 60-61.

Caregivers should participate in and encourage “serve and return” interactions with infants. Serve and return interactions shape brain architecture. When an infant or young child babbles, gestures, or cries, and an adult responds appropriately with eye contact, words, or a hug, neural connections are built and strengthened in the child's brain that support the development of communication and social skills. Much like a game of tennis, volleyball, or Ping-Pong, this back-and-forth is both fun and capacity-building. When caregivers are sensitive and responsive to a young child's signals and needs, they provide an environment rich in serve and return experiences. Read more at The Center on the Developing Child at Harvard University.

Compliance Guidelines
• Give infants attention by making eye contact and smiling.
• Engage in and encourage “serve and return” interactions, where caregivers are attuned to children's feelings and reflect them back.
• Use a variety of safe and appropriate individualized soothing techniques of holding and comforting children who are upset.
• Talk, sing and read to infants and toddlers.
• Be partners in play as well as caregivers and protectors.

Risk Level
Moderate
Corrective Action for 1st Instance
Citation Warning
(2) To stimulate their healthy development, the provider shall ensure that infants receive daily interactions with adults; including on the ground interaction and closely supervised time spent in the prone position for infants less than six months old.

**Rationale/Explanation**
Infants should have supervised tummy time every day when they are awake. Beginning on the first day at the early care and education program, caregivers/teachers should interact with an awake infant on his/her tummy for short periods (3–5 minutes), increasing the amount of time as the infant shows he/she enjoys the activity.

There are many ways to promote tummy time with infants:

a. Place yourself or a toy just out of the infant’s reach during playtime to get him/her to reach for you or the toy.

b. Place toys in a circle around the infant. Reaching to different points in the circle will allow him/her to develop the appropriate muscles to roll over, scoot on his/her belly, and crawl.

c. Lie on your back and place the infant on your chest. The infant will lift his/her head and use his/her arms to try to see your face. CFOC 4th ed. Standard 3.1.2.1 p.p. 97.

**Compliance Guidelines**
Each young infant must have a daily opportunity for tummy time. Although it is not required for the caregiver to be on their stomach during this activity, they must be close enough to interact with and actively supervise the infant.

**Risk Level**
Moderate

**Corrective Action for 1st Instance**
Citation Warning

(3) The provider shall ensure that caregivers respond promptly to infants and toddlers who are in emotional distress due to conditions such as hunger, fatigue, a wet or soiled diaper, fear, teething, or illness.

**Rationale/Explanation**
Holding, and hugging, in a positive, respectful, and safe manner is an essential part of providing care for infants and toddlers. Quality caregivers/teachers provide care and learning experiences that play a key role in a child's development as an active, self-knowing, self-respecting, thinking, feeling, and loving person; CFOC 4th ed. Standard 2.1.2.1 p.p. 60.

**Compliance Guidelines**
“Promptly” responding to infants and toddlers who are in emotional distress means responding immediately or as soon as possible if the caregiver is diapering, feeding, or administering first aid to another child. A caregiver who is unable to immediately respond to a child in distress (due to another child’s immediate needs) should still reassure the distressed child by making eye contact and speaking to the child in a reassuring tone of voice.
(4) For their healthy development, the provider shall make safe toys available and accessible for each infant and toddler to engage in play.

**Rationale/Explanation**
Opportunities to be an active learner are vitally important for the development of motor competence and awareness of one's own body and person, the development of sensory motor skills, the ability to demonstrate initiative through active outdoor and indoor play, and feelings of mastery and successful coping. Coping involves original, imaginative, and innovative behavior as well as previously learned strategies. CFOC 4th ed. Standard 2.1.2.3 p.p. 61.

**Compliance Guidelines**
There must be enough toys available (within their reach) for each infant and toddler in the group to be engaged in play with at least one toy, even when some of the toys are removed to be cleaned.

(5) The provider shall ensure that mobile infants and toddlers have freedom of movement in a safe area.

**Rationale/Explanation**
Keeping an infant confined in a piece of infant equipment prevents an infant from active movement. Infants need the opportunity to play on the floor in a safe open area to develop their gross motor skills. If infants are not given the opportunity for floor time, their development can be hindered or delayed. The shape of an infant's head can be affected if pressure is applied often and for long periods of time. This molding of the skull is called plagiocephaly. Due to the recommendation for back sleeping, an infant's skull already experiences a great amount of time with pressure on the back of the head. When an infant is kept in a piece of infant equipment such as an infant seat or a swing, the pressure again is applied to the back of an infant's head; thus, increasing the likelihood of plagiocephaly. To prevent plagiocephaly and to promote normal development, infants should spend time on their tummies when awake and supervised. CFOC 4th ed. Standard 5.3.1.10 p.p. 258-259

**Compliance Guidelines**
“Freedom of movement” means that infants and toddlers are not restrained from moving, crawling, walking, roaming, and exploring in a developmentally appropriate way.
The provider may not confine an awake infant or toddler in any piece of equipment, such as a swing, high chair, crib, playpen, or other similar piece of equipment for more than 30 minutes.

Rationale/Explanation
Restrictive infant equipment such as swings, stationary activity centers (e.g., exersaucers), infant seats (e.g., bouncers), molded seats, etc., if used, should only be used for short periods of time. Infants should not be placed in equipment until they are developmentally ready. Infants should be supervised when using equipment. Safety straps should be used if provided by the manufacturer of the equipment. Equipment should not be placed on elevated surfaces, uneven surfaces, near the top of stairs, or within reach of safety hazards. CFOC 4th ed. Standard 5.3.1.10 p.p. 258-259.

Compliance Guidelines
Being confined includes being in a gated-off play yard or similar area with a barrier for more than 30 minutes at a time unless there are at least 35 square feet of space per child.

This rule is not out of compliance if a child is in a high chair for more than 30 minutes because they are still eating.

The provider shall ensure that only one infant or toddler occupies any one piece of equipment at a time, unless the equipment has individual seats for more than one child.

Rationale/Explanation
The purpose of this rule is to prevent infants and toddlers from accidentally injuring one another and to ensure equipment is used as intended by the manufacturer.

Compliance Guidelines
This rule is not out of compliance when:
• A caregiver uses a crib to evacuate multiple children for an emergency drill or an actual emergency evacuation.
• More than one infant or toddler is in a wagon that is intended to hold more than one child.
The provider shall make objects made of styrofoam inaccessible to infants and toddlers.

**Rationale/Explanation**
Foam objects can break into pieces that can become choking hazards for young children.

**Compliance Guidelines**
- Styrofoam refers to expanded polystyrene foam that is typically white in color. This type of foam can be easily broken into pieces because it is made with circular individual beads of foam.
- Swimming noodles are not made of styrofoam and do not need to be inaccessible to the children.
- Styrofoam inside a bike helmet is only a hazard when it is deteriorated to the point that it is crumbly and/or cracked.
- Infants and toddlers may use styrofoam objects only when they are involved in a carefully supervised activity. This means a caregiver is within arm's reach of the children, providing constant, active supervision, and does not leave until the materials are made inaccessible.

**Risk Level**
Moderate

The provider shall allow each infant and toddler to eat and sleep on their own schedule.

**Rationale/Explanation**
Responsive feeding meets the infant's nutritional and emotional needs and provides an immediate response to the infant, which helps ensure trust and feelings of security.

In the young infant, favorable conditions for sleep and rest include being dry, well fed, and comfortable. Infants may need 1 or 2 (or sometimes more) naps during the time they are in child care. As infants age, they typically transition to 1 nap per day, and having 1 nap per day is consistent with the schedule that most facilities follow. Different practices, such as rocking, holding a child while swaying, singing, reading, or patting an arm or back, could be used to calm the child. Lighting does not need to be turned off during nap time. CFOC 4th ed. Standard 3.1.4.4 p.p. 107.

**Compliance Guidelines**
Older toddlers may begin to be eased into group schedules for eating and napping. However, any toddler who is tired must be allowed to rest and any toddler who is hungry must be given
something to eat.

**Risk Level**
Moderate

**Corrective Action for 1st Instance**

Citation Warning

(10) **The provider shall ensure that baby food, formula, or breast milk that is brought from home for an individual child's use is:**
(a) labeled with the child's name;
(b) labeled with the date and time of preparation or opening of the container, such as a jar of baby food;
(c) kept refrigerated if needed; and
(d) discarded within 24 hours of preparation or opening, except for unprepared powdered formula or dry food.

**Rationale/Explanation**
Labeling food and drink with the child's name ensures that the child is not accidentally fed the wrong food that could cause an unhealthy reaction due to such causes as an allergy or inability to digest a certain food. Keeping baby food, formula, and breast milk refrigerated, if needed, and discarding the food within 24 hours of preparation ensures that a child does not become ill from eating spoiled food. CFOC 4th ed. Standards 4.3.1.3-4.3.1.5 p.p. 176-179.

**Compliance Guidelines**

*Labeled with the child's name, and the date and time of preparation*
- If a caregiver prepares a bottle and immediately feeds it to a child, the bottle does not have to be labeled. However, if any formula or breast milk remains in the bottle and is not immediately discarded, the bottle has to be labeled with the child's name, date, and time of preparation.
- Breast milk for a caregiver's own child does not need to be labeled with the time of preparation.

*Kept refrigerated if needed*
- For information about storing homemade and commercial baby food and formula, refer to:
  - [www.foodsafety.gov/blog/homemade_babyfood.html](http://www.foodsafety.gov/blog/homemade_babyfood.html).
  - Instructions on baby food and formula packaging.
- For information about storing breast milk, refer to:
  - [https://www.cdc.gov/breastfeeding/recommendations/handling_breastmilk.htm](https://www.cdc.gov/breastfeeding/recommendations/handling_breastmilk.htm).

*Discarded within 24 hours of preparation or opening*
- This rule does not apply to containers (pint, quart, half gallon, or gallon) of milk that are purchased from the store nor to solid adult food.
- Preparation of food includes mixing a powder with a liquid, opening a jar of food, or removing frozen breast milk from the freezer to thaw.
Breast milk that is frozen immediately after collection is not considered "prepared" or "opened" until it is moved to the refrigerator to thaw. It must be discarded within 24 hours after it has completely thawed.

**Risk Level**
Moderate

**Corrective Action for 1st Instance**
Citation Warning

(11) If an infant cannot sit upright and hold their own bottle, the provider shall ensure that a caregiver holds the infant during bottle feeding and that bottles are not propped.

**Rationale/Explanation**
Caregivers/teachers should hold infants who are bottle feeding whenever possible, even if the children are old enough to hold their own bottle. Caregivers/teachers should promote proper feeding practices and oral hygiene including proper use of the bottle for all infants and toddlers. 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. CFOC 4th ed. Standard 4.3.1.8 p.p. 181.

**Compliance Guidelines**
• As long as the caregiver holds the infant while bottle feeding, a device to hold the bottle (such as a Beebo) may be used.
• If a child is able to sit upright and hold their own bottle, the rule is not out of compliance if the child is drinking a bottle while lying down.

**Risk Level**
Moderate

**Corrective Action for 1st Instance**
Citation Warning

(12) The provider shall ensure that the caregiver swirls and tests warm bottles for temperature before feeding to children.

**Rationale/Explanation**
Bottles of human milk or infant formula that are warmed at room temperature or in warm water for an inappropriate period provide an ideal medium for bacteria to grow. Infants have received burns from hot water dripping from an infant bottle that was removed from a crock-pot or by pulling the crock-pot down on themselves by means of a dangling cord. Caution should be exercised to avoid raising the water temperature above a safe level for warming infant formula or infant food. Bottles and infant foods should never be warmed in a microwave oven. CFOC 4th ed. Standard 4.3.1.9 p.p. 182.

Gently swirling a warmed bottle before bottle feeding prevents burns from "hot spots" in the
heated liquid. Gentle swirling is important, because excessive shaking of human milk may damage the nutrient quality of the milk that is valuable to infants. Excessive shaking of formula may cause foaming, which increases the likelihood of feeding air to infants.

**Compliance Guidelines**
When mixing powdered formula with water, it is not out of compliance to shake the bottle.

**Risk Level**
Low

**Corrective Action for 1st Instance**
Warning

(13) The provider shall discard formula and milk, including breast milk, after feeding or within two hours of starting a feeding.

**Rationale/Explanation**
The purpose of this rule is to prevent children from drinking spoiled milk or formula, and to prevent the spread of disease. Within a short period of time, bacteria introduced by the child's saliva can make the formula or milk unsuitable and unsafe for consumption. CFOC 4th ed. Standard 4.3.1.3; Standard 4.3.1.5; Standard 4.3.1.8 p.p. 176-179.

**Risk Level**
Moderate

**Corrective Action for 1st Instance**
Citation Warning

(14) The provider shall ensure that caregivers cut solid foods for infants into pieces no larger than 1/4 inch in diameter, and cut solid foods for toddlers into pieces no larger than 1/2 inch in diameter.

**Rationale/Explanation**
Almost 90% of fatal choking occurs in children younger than four years of age (2-7). Peanuts may block the lower airway. A chunk of hot dog or a whole seedless grape may completely block the upper airway (2-8,10). The compressibility or density of a food item is what allows the food to conform to and completely block the airway. Hot dogs are the foods most commonly associated with fatal choking in children. Caregivers/teachers should not offer to children under four years of age foods that are associated with young children's choking incidents (round, hard, small, thick and sticky, smooth, compressible or dense, or slippery). Examples of these foods are hot dogs and other meat sticks (whole or sliced into rounds), raw carrot rounds, whole grapes, hard candy, nuts, seeds, raw peas, hard pretzels, chips, peanuts, popcorn, rice cakes, marshmallows, spoonfuls of peanut butter, and chunks of meat larger than can be swallowed whole. CFOC 4th ed. Standard 4.5.0.10 p.p. 192-193.

**Compliance Guidelines**
Food that does not quickly dissolve or crumble in the mouth without chewing needs to be cut into small pieces. For infants, pieces of food may be no larger than ¼ inch x ¼ inch. For toddlers, pieces of food may be no larger than ½ inch x ½ inch. Examples of solid foods that must be cut include:
- Cheese (except shredded).
- Fruit including bananas, grapes, and other fruit chunks.
- Marshmallows.
- Meat including hot dogs, meat chunks, and meatballs.
- Raw vegetables including carrots, beans, and tater tots.

**Risk Level**
Moderate

**Corrective Action for 1st Instance**
Citation Warning

(15) The provider shall ensure that infants sleep in equipment designed for sleep such as a crib, bassinet, porta-crib or playpen, and that infants are not placed to sleep on a mat, cot, pillow, bouncer, swing, car seat, or other similar piece of equipment.

**Rationale/Explanation**
Injuries and Sudden Infant Death Syndrome (SIDS) have occurred when children have been left to sleep in car seats or infant seats when the straps have entrapped body parts, or the children have turned the seats over while in them. Sleeping in a seated position can restrict breathing and cause oxygen desaturation in young infants. Sleeping should occur in equipment manufactured for this activity. CFOC 4th ed. Standard 2.2.0.2 p.p. 69-70.

Cradles and bassinets are not immune to the hazards that may cause SIDS. Ninety percent of SIDS cases occur during the first six months of a baby's life, which is prime bassinet time. CPSC safety guidelines stipulate: 1) a sturdy bottom and wide base; 2) smooth surfaces without protruding hardware; 3) legs with locks to prevent folding while in use; 4) a firm, snugly fitting mattress; and 5) adherence to the manufacturer’s guidelines regarding maximum weight and size of the infant. Pike, Jodi & Moon, Rachel. (2008). Bassinet Use and Sudden Unexpected Death in Infancy. Journal of Pediatrics. p.p. 509-512.

**Compliance Guidelines**
- Cribs, bassinets, cradles, porta-cribs, playpens, and play yards are approved to sleep infants as long as they meet sleep equipment rules in “Section 22: Rest and Sleep."
- A crib is defined as a child’s bed that has sides for protection from falling.
- The following equipment is not approved to sleep infants:
  - A mat, cot, pillow, bouncer, swing, or car seat
  - Any size bed
  - A crib that has been converted into a toddler bed
  - A couch or chair even if the caregiver is sitting next to the infant
  - A Boppy pillow even if it is placed on or in a bed, crib, cradle, bassinet, playpen, or play
yard (Improper use of this product could result in serious injury or death.)
- A bassinet or cradle if the infant is able to push up on hands and knees, pull up, or sit unassisted
- Loungers and co-sleepers
- Previously approved sleep equipment that has been recalled by CPSC.

• Before a caregiver sleeps an infant in equipment such as a motion glider, rocker, bouncer or napper, the provider must obtain written documentation from the manufacturer stating that the equipment is approved for sleeping infants. The documentation must be available for review by licensing staff.
• Equipment marked as intended for “supervised napping”, and not for overnight sleep, is not approved sleep equipment and requires a parent's written permission for an infant to sleep in it.
• Infants may not sleep on blankets inside on the floor or on the ground in the outdoor area.
• Caregivers may take approved equipment outside to use for sleeping the infant.
• It is not a rule violation if an infant is asleep in a car seat when arriving at the facility, and a caregiver within 5 minutes moves the infant to appropriate sleeping equipment. It is a rule violation if more than 5 minutes elapse before the infant is moved.
• It is not a rule violation if an infant falls asleep in a piece of equipment not designed for sleeping, and a caregiver immediately (within 5 minutes) moves the infant to appropriate sleeping equipment. It is a rule violation if more than 5 minutes elapse before the infant is moved.
• A caregiver may hold an infant while the infant sleeps.
• Wearing a sleeping infant by using a sling or wrap is acceptable and there is no need to move the infant to a piece of sleep equipment.

**Risk Level**
High

**Corrective Action for 1st Instance**
Citation and CMP Warning

(16) The provider shall place infants on their backs for sleeping unless there is documentation from a health care provider requiring a different sleep position.

**Rationale/Explanation**
About 3,500 SUIDs occurred in the U.S. in 2014. Most sleep-related deaths in child care facilities occur in the first day or first week that an infant starts attending a child care program. Many of these deaths appear to be associated with prone (tummy) positioning, especially when the infant is unaccustomed to being placed in that position. CFOC 4th ed. Standard 3.1.4.1 p.p. 102-105.

For more information about safe sleep practices for infants, visit the [National Institutes of Health: Safe to Sleep](https://parenting.nationalinstitutesofhealth.nih.gov/infant/safe-sleep.aspx).

**Compliance Guidelines**
Infants should always be placed on their back to sleep, but if they roll over on their own they do not need to be returned to their back.
(17) The provider may not place soft toys, loose blankets, or other objects in sleep equipment while in use by sleeping infants.

Rationale/Explanation

Safe Sleep Environment
Each year in the United States, thousands of babies die suddenly and unexpectedly. Some of these deaths result from unknown causes, such as SIDS, while others are from other sleep-related causes of infant death. Creating a safe sleep environment by keeping the following items out of an infant's sleep area reduces the risk of SIDS, suffocation, entrapment, and strangulation:
- Toys and objects such as stuffed animals
- Soft or loose bedding such as blankets, pillows, quilts, comforters, flat sheets, sheep skins
- Other soft objects such as bumper pads, sleep positioning devices, cloth diapers, etc.

Blankets
Soft or loose bedding should be kept away from sleeping infants and out of safe sleep environments. These include, but are not limited to: bumper pads, pillows, quilts, comforters, sleep positioning devices, sheepskins, blankets, flat sheets, cloth diapers, etc. Also, blankets/items should not be hung on the sides of cribs. Loose or ill-fitting sheets have caused infants to be strangled or suffocated. The caregiver/teacher should remain alert and should actively supervise sleeping infants in an ongoing manner. The caregiver/teacher should check to ensure that the infant's head remains uncovered and re-adjust clothing as needed. CFOC 4th ed. Standard 3.1.4.1 p.p. 102-105.

Adults sometimes find it difficult to place an infant to sleep without a blanket. If a blanket is used, it should not be loose and the “Feet to Foot Rule” should be followed. This involves placing the child's feet at the foot of the crib, and tucking a light blanket along the sides and under the foot of the crib. The blanket is placed only up to the infant's chest with their arms outside of the blanket. CFOC 3rd ed. Standard 3.1.4.1 p.p. 98.

Swaddling
Swaddling infants when they are in a crib is not necessary or recommended, but rather one-piece sleepers should be used. There is evidence that swaddling can increase the risk of serious health outcomes, especially in certain situations. The risk of sudden infant death is increased if an infant is swaddled and placed on his/her stomach to sleep or if the infant can roll over from back to stomach. Loose blankets around the head can be a risk factor for sudden infant death syndrome (SIDS). With swaddling, there is an increased risk of developmental dysplasia of the hip, a hip
condition that can result in long-term disability. Hip dysplasia is felt to be more common with swaddling because infants' legs can be forcibly extended. With excessive swaddling, infants may overheat. CFOC 4th ed. Standard 3.1.4.1 p.p. 102-105; Standard 3.1.4.2 p.p.105.

For more information about safe sleep practices, visit the American Academy of Pediatrics website at: www.aap.org and the National Institutes of Health at: safetosleep.nichd.nih.gov.

Compliance Guidelines
• This rule only applies to infants who are asleep.
• Objects that are possible hazards for a sleeping infant must not be in or on sleep equipment or within 36 inches of the sleep equipment while the infant is asleep. This includes objects that may increase risk of SIDS, or cause entrapment, strangulation, suffocation, or choking.
Examples of prohibited objects include but are not limited to:
  - Soft and hard toys
  - Crib bumpers or bumper pads (regardless of their type)
  - Baby gyms
  - Mobiles
  - Pacifiers with attached ribbons, toys, and/or other objects. (Plain pacifiers on a cord of 8 inches or less are allowed)
  - Bedding and other fabric products that are loose, including blankets, pillows, sheets, comforters, cloth diapers, clothing, etc.
• Appropriate options
  - The room where the infant sleeps is kept at a safe and comfortable temperature.
  - For needed warmth, the infant is placed in sleep clothing such as a sleepsack, a swaddler, pajamas. etc. All sleep attire should fit properly and never cover the infant's neck or face. Follow manufacturer’s instructions regarding use recommendations for child's age and size.
  - Swaddling an infant is appropriate until they show signs of rolling over. Once an infant shows signs of rolling over, arms should not be restrained.

The following exceptions to this rule are allowed under certain conditions:
• If an infant needs a comfort item to help them go to sleep, it is not a rule violation if the item is removed as soon as the infant falls asleep.
• An infant may sleep with a bib that is secured on the infant, but a bib that is not attached to the child, loose in the sleep equipment is not allowed.
• An infant's pacifier is allowed to remain with a sleeping infant on condition that there are no loose parts or tears on the pacifier and any objects attached to the pacifier (e.g. ribbons, toys) are removed before use or as soon as the infant falls asleep. A pacifier cord that is less than 8 inches long does not have to be removed.
• Although two cribs may be within 36 inches of each other, each crib will be assessed for any loose bedding that may be in or on it, and not for loose bedding in the adjacent crib.
• If fabric (other than a blanket or bumper) is securely attached to the top of a crib rail to prevent children from chewing on the rail, it is not a rule violation.
• An item may be attached in the crib as long as it is not on the sleeping surface, with the exception of mobiles which cannot be within 36° of the sleeping surface.
Risk Level
Moderate
Corrective Action for 1st Instance
Citation Warning
In Compliance

NOT in Compliance
This document is not rule. Instead, it is a tool to help as a quick reference to some of the Child Care Licensing (CCL) rules. This document will be updated as needed, but at least once a year. For complete access to the rules and their interpretation, please go to https://childcarelicensing.utah.gov/Rules.html.

For CCL, all records must be kept on-site for at least six weeks or longer depending upon the action or event that is documented. Children's and personnel records must be current and kept on-site while the individual is involved with the program, and for six weeks after the individual leaves the program. The business license and other facility records, such as fire inspection reports, must be current and kept on-site for at least 6 weeks after their expiration dates. At least 12 months of fire and disaster drills must be kept on-site for review by CCL. Other agencies, such as the local health department, the food program, or the IRS, may require that records be kept for a longer period of time.

### Records: Children

<table>
<thead>
<tr>
<th>Rule</th>
<th>Record</th>
<th>Requirement</th>
</tr>
</thead>
</table>
| 50-6(10) - (11)     | Admission & Health Assessment for each child including emergency medical treatment & emergency transportation releases | • Obtain from parent before admission into program  
• Update annually  
• Keep on-site for CCL review |
| 50-6(12) - (13)     | Immunization records for each infant, toddler & preschooler           | • Obtain before child’s admission into program  
• Must be current  
• Keep on-site for CCL review |
| 50-11(6), (8)       | Children's daily attendance including sign-in and signout records     | • Document daily  
• Keep 6-week record on-site for CCL review |
| 50-14(7)            | Incident, accident or injury involving child                         | • Give written report to parent on day of occurrence |
| 50-14(10)           | Child received medical attention for injury while in care or for fatality | • Notify CCL within next business day  
• Submit written report within 5 business days |
| 50-17(4)- (7)       | Medication permission & instructions                                 | Must be filled out and signed by child's parent before administering medication |
| 50-17(9), (12)      | Medication administration record                                     | • Complete immediately after administering medication  
• Keep 6-week record on-site for CCL review |
| 50-18(5), (6)       | Parental permission for swimming &                                   | Obtain before each activity |
### Records: Personnel

<table>
<thead>
<tr>
<th>Rule</th>
<th>Record</th>
<th>Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>50-7(16)</td>
<td>First aid and CPR certification</td>
<td>Keep on-site for CCL review</td>
</tr>
<tr>
<td>50-8(1) - (6)</td>
<td>• Background check form &amp; fees for new covered individuals&lt;br&gt;• Fingerprint &amp; fees as required per rule</td>
<td>• Submit to CCL&lt;br&gt;• Individual must pass CCL background check before involvement with child care</td>
</tr>
<tr>
<td>50-20(4)</td>
<td>Current driver’s license for each driver</td>
<td>• Valid for the type of vehicle being driven&lt;br&gt;• Carried with the driver</td>
</tr>
</tbody>
</table>

### Records: Facility

<table>
<thead>
<tr>
<th>Rules</th>
<th>Record</th>
<th>Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>50-14(1)</td>
<td>Emergency Preparedness, Response and Recovery Plan</td>
<td>• Complete before beginning to provide care&lt;br&gt;• Reviewed and updated as needed&lt;br&gt;• Available during business</td>
</tr>
<tr>
<td>50-16(2)</td>
<td>Meal &amp; snack menus if not on CACFP</td>
<td>• Current Approval&lt;br&gt;• Keep 6-week record on-site for CCL review</td>
</tr>
<tr>
<td>50-21(8)- (9)</td>
<td>Animal vaccination records</td>
<td>• Must be current&lt;br&gt;• Keep onsite for CCL review</td>
</tr>
<tr>
<td>Rule</td>
<td>Report</td>
<td>Requirement</td>
</tr>
<tr>
<td>--------------</td>
<td>--------------------------------------------------</td>
<td>-------------------------------------------------------------------</td>
</tr>
<tr>
<td>50-14(10)</td>
<td>Serious incident, accident or injury involving a child</td>
<td>Give written report to parent on day of occurrence</td>
</tr>
<tr>
<td>50-6(14)</td>
<td>Annual immunization report</td>
<td>• Submit report to Immunization Program annually • Usually Oct 1-Nov 30</td>
</tr>
<tr>
<td>50-14(12)-(13)</td>
<td>Emergency substitute background statement</td>
<td>• Obtain before leaving children in care of the emergency substitute • Submit to CCL within 5 working days of occurrence</td>
</tr>
</tbody>
</table>

### Notifications

<table>
<thead>
<tr>
<th>Rule</th>
<th>Notification</th>
<th>Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>50-6(7)</td>
<td>Telephone number &amp; contact information change</td>
<td>Notify CCL &amp; parents within 48 hours of change</td>
</tr>
<tr>
<td>50-6(8)</td>
<td>Liability Insurance</td>
<td>Inform parents in writing if no liability insurance</td>
</tr>
<tr>
<td>50-8(14)</td>
<td>Arrest warrant, felony or misdemeanor arrest, charge, conviction, or supported LIS finding</td>
<td>Notify CCL within 48 hours of becoming aware of occurrence</td>
</tr>
<tr>
<td>50-9(6)</td>
<td>Lead-based paint testing</td>
<td>• Contact local health department within 5 working days of discovery • Follow instructions for remediation</td>
</tr>
<tr>
<td>50-12(2)</td>
<td>Behavioral expectations for children &amp; how misbehavior will be handled</td>
<td>Inform children, parents &amp; those who interact with children</td>
</tr>
<tr>
<td>50-12(6)</td>
<td>Child abuse, neglect, or exploitation</td>
<td>Notify CPS or law enforcement immediately upon witnessing or suspicion</td>
</tr>
<tr>
<td>50-14(8)</td>
<td>Serious, but not life-threatening injury involving a child</td>
<td>Contact parent of child immediately</td>
</tr>
<tr>
<td>50-14(9)</td>
<td>Life-threatening injury or injury that poses threat of loss of vision, hearing, or limb involving a child</td>
<td>• Contact emergency personnel immediately • Contact parent after emergency personnel • Contact emergency contacts if parents cannot be reached</td>
</tr>
<tr>
<td>50-14(10)</td>
<td>Child received medical attention for injury while in care or for fatality</td>
<td>• Notify CCL within next business day • Submit written report within 5 business days</td>
</tr>
<tr>
<td>Rule</td>
<td>Posted Item</td>
<td>Requirement</td>
</tr>
<tr>
<td>------------</td>
<td>------------------------------------------------------</td>
<td>----------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| 50-15(20)  | Child becomes ill while in care                      | • Contact parent immediately  
               |                                                        | • Contact emergency contacts if parents cannot be reached                  |
| 50-15(21)  | Staff member or child has infectious disease or parasite | Notify parents on day illness is discovered                                  |
| 50-15(22)  | Child or employee with infectious or unusual disease or serious illness | Notify local health department on day of discovery                          |
| 50-17(10)  | Child's adverse reaction to medication or error in administration | • Notify emergency personnel immediately if reaction is life threatening   
               |                                                        | • Report to parent immediately upon recognizing reaction or error or after notifying emergency personnel |
| 50-17(11)  | Provider's refusal to administer medication          | Notify parent before medication needs to be given to child                  |
| 50-21(1)   | Animals permitted at facility                        | Inform parents of the kinds of animals allowed                              |

**Posted Items**

<table>
<thead>
<tr>
<th>Rule</th>
<th>Posted Item</th>
<th>Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>50-6(5)</td>
<td>Child Care License</td>
<td>Post unaltered in visible location</td>
</tr>
<tr>
<td>50-6(6)</td>
<td>Parent Guide</td>
<td>Post current version during business hours for parents’ review or make it otherwise available to parents.</td>
</tr>
<tr>
<td>50-14(2)</td>
<td>Emergency numbers with facility address</td>
<td>Post near each telephone or in clearly visible area</td>
</tr>
<tr>
<td>50-16(2)</td>
<td>Meal &amp; snack menus</td>
<td>Post current week’s menu for review by parents and CCL</td>
</tr>
</tbody>
</table>