

**MALTREATMENT INVESTIGATION MEMORANDUM
Office of Inspector General, Licensing Division
Public Information**

Minnesota Statutes, section 260E.01, paragraph (a), "The legislature hereby declares that the public policy of this state is to protect children whose health or welfare may be jeopardized through maltreatment."

Report Number: 202207778

Date Issued: November 18, 2022

Name and Address of Facility Investigated:

Discover Little Miracles Child Care
13065 43rd Street NE
Saint Michael, MN 55376

Disposition: Maltreatment determined as to physical abuse of an alleged victim by a staff person.

License Number and Program Type:

1082479-CCC (Child Care Center)

Investigator(s):

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Suspected Maltreatment Reported:

It was reported that on the morning of September 19, 2022, a staff person (SP) hit an alleged victim (AV) on his/her head, twice.

Date of Incident(s): September 19, 2022

Nature of Alleged Maltreatment Pursuant to Minnesota Statutes, section 260E.03, subdivision 18, paragraph (a), and subdivision 23, paragraph (a):

"Physical abuse" means any physical injury, mental injury, or threatened injury, inflicted by a person responsible for the child's care on a child other than by accidental means. "Threatened injury" means a statement, overt act, condition, or status that represents a substantial risk of physical or sexual abuse or mental injury.

Summary of Findings:

Pertinent information was obtained during a site visit conducted on September 23, 2022; from documentation at the facility; and through three interviews conducted with the SP, an administrative staff person (P), and a family member (FM) of the AV. The SP was a staff person at the facility as well as the AV's family member.

The AV was six years old and was enrolled in the facility's school-age classroom.

The facility's preschool room was a large open room. In the morning, on occasion, some of the school-age children ate breakfast in the preschool room before they went to school.

Information from the facility showed the following:

- The video camera's clock was behind an hour from the actual time.
- On September 19, 2022, the SP worked from 8 a.m. to 5:21 p.m., with an hour break from 1:15 -2:15 p.m.

Video footage on the day of the incident showed that at 8:19 a.m. (7:19 a.m. on the video), in the preschool room, there were five children, including the AV and the SP. The children were sitting at a table. The AV was sitting in a chair, with his/her back to the video camera. The AV's chair was backed away from the table. The SP walked over to the AV and used his/her open hand to hit the AV in the forehead. Then the SP pushed the AV's chair in towards the table and told him/her, "Knock it off, right now." The SP asked the AV if s/he wanted to go home and when the AV said something (that could not be determined), the SP hit the AV on the right side of his/her temple with what appeared to be the back of the SP's hand, then told the AV, "Stop it." The SP then walked away and told the AV to "be nice to people."

The SP provided the following information:

- On the day of the incident, the SP stepped into the Bluebird room for thirty minutes, around breakfast time. The AV who was also the SP's child, was in the room. The SP recalled that the AV had been lifting up the front of the chair s/he was sitting in and the SP told him/her to stop doing that because s/he did not want the AV to fall. The SP pushed the AV's chair in, but denied doing so in an aggressive manner. The AV had also been calling other children names and was using "potty talk," so the SP told the AV that his/her words were not appropriate. The AV was not happy with who s/he had to sit by. The SP denied "purposefully smack[ing]" or pushing the AV's head. The SP stated that s/he may have "tapped" the AV's head, but not in a rough manner because they were "goofing around."
- When asked if the SP would treat other children at the facility in the same manner s/he treated the AV, the SP said, "No."

The P did not have any concerns with the interactions between the SP and children at the facility.

The FM stated that the SP "hits [the AV] constantly." The AV had not told the FM about any concerns at the facility.

The facility's *Employee Handbook* stated that staff persons provided children with positive guidance through clear, concise, open, honest communication. Children were to be guided in ways that enhanced their self-esteem, self-control, and respect for the rights of themselves and others. The facility prohibited all forms of physical and

verbal punishment including humiliating, frightening, hitting, spanking, verbal, or sexual abuse.

Facility documentation showed that the SP and P1 each received training on the facility's policies as well as the Reporting of Maltreatment of Minors Act.

Law enforcement was aware of the allegation, but at the conclusion of this investigation, it was unclear if they were going to be investigating the incident.

Relevant Rules and/or Statutes:

Minnesota Rules, part 9503.0055, subpart 3, item A, states that the license holder must have and enforce a policy that prohibits actions by or at the direction of a staff person to subject a child to corporal punishment including rough handling, shoving, hair pulling, ear pulling, shaking, slapping, kicking, biting, pinching, hitting, and spanking.

Conclusion:

A. Maltreatment:

Video footage from the morning of September 19, 2022, showed that the SP hit the AV's forehead with an open hand and then hit the AV's temple with the back of his/her hand. The SP's actions were inconsistent with the standards of a professional caregiver in a facility licensed by the Department of Human Services and were violations of the facility's policies and were violations of Minnesota Rules, part 9503.0055, subpart 1, item A, and subpart 3, item A.

Although the SP stated that s/he may have "tapped" the AV's head, the audio from the video footage showed that the SP was verbally reprimanding the AV at the time and did not appear to be "goofing off" with the AV, as the SP stated.

Given the above information, that the SP was working in the capacity of a staff person at the time of the incident, and that the SP's actions were not accidental in nature and represented a risk of injury to the AV, there was a preponderance that physical abuse occurred.

It was determined that physical abuse occurred ("physical abuse" means any physical injury, mental injury, or threatened injury, inflicted by a person responsible for the child's care on a child other than by accidental means. "Threatened injury" means a statement, overt act, condition, or status that represents a substantial risk of physical or sexual abuse or mental injury).

B. Responsibility pursuant to Minnesota Statutes, section 260E.30, subdivision 4, paragraph (a), clauses (1) and (2):

When determining whether the facility or individual is the responsible party, or whether both the facility and the individual are responsible for determined maltreatment in a facility, the investigating agency shall consider at least the following mitigating factors:

- (1) whether the actions of the facility or the individual caregivers were according to, and followed the terms of, an erroneous physician order, prescription, individual care plan, or directive; however, this is not a mitigating factor when the facility or caregiver was responsible for the issuance of the erroneous order, prescription, individual care plan, or directive or knew or

should have known of the errors and took no reasonable measures to correct the defect before administering care;

- (2) comparative responsibility between the facility, other caregivers, and requirements placed upon an employee, including the facility's compliance with related regulatory standards and the adequacy of facility policies and procedures, facility training, an individual's participation in the training, the caregiver's supervision, and facility staffing levels and the scope of the individual employee's authority and discretion; and
- (3) whether the facility or individual followed professional standards in exercising professional judgment.

The SP received training on the facility's policies and the Reporting of Maltreatment of Minors Act prior to the incident. The SP was responsible for the maltreatment of the AV.

C. Recurring and/or Serious Maltreatment:

The Office of Inspector General is required to evaluate whether substantiated maltreatment by an individual meets the statutory criteria to be determined as "recurring or serious." Individuals determined to be responsible for recurring or serious maltreatment are disqualified from providing direct contact services. Minnesota Statutes, section 245C.02, subdivision 16, states:

"Recurring maltreatment" means more than one incident of maltreatment for which there is a preponderance of evidence that maltreatment occurred and that the subject was responsible for the maltreatment.

Minnesota Statutes, section 245C.02, subdivision 18, states:

"Serious maltreatment" means sexual abuse, maltreatment resulting in death, neglect resulting in serious injury which reasonably requires the care of a physician whether or not the care of a physician was sought, or abuse resulting in serious injury. For purposes of this definition, "care of a physician" is treatment received or ordered by a physician, physician assistant, or nurse practitioner, but does not include diagnostic testing, assessment, or observation; the application of, recommendation to use, or prescription solely for a remedy that is available over the counter without a prescription; or a prescription solely for a topical antibiotic to treat burns when there is no follow-up appointment. For purposes of this definition, "abuse resulting in serious injury" means: bruises, bites, skin laceration, or tissue damage; fractures; dislocations; evidence of internal injuries; head injuries with loss of consciousness; extensive second-degree or third-degree burns and other burns for which complications are present; extensive second-degree or third-degree frostbite and other frostbite for which complications are present; irreversible mobility or avulsion of teeth; injuries to the eyes; ingestion of foreign substances and objects that are harmful; near drowning; and heat exhaustion or sunstroke. Serious maltreatment includes neglect when it results in criminal sexual conduct against a child or vulnerable adult.

It was determined that the substantiated physical abuse for which the SP was responsible did not meet statutory

criteria to be determined as recurring because the incident was considered a pattern of events and it was not serious because the AV did not sustain an injury.

Pursuant to Minnesota Statutes, section 260E.35, subdivision 6, paragraph (c) all investigative data maintained in this report will be kept by the Department of Human Services for at least ten years after the date of the final entry in the report.

Action Taken by Facility:

The facility completed an internal review and determined that their policies and procedures were adequate but not followed by the SP.

Action Taken by Department of Human Services, Office of Inspector General:

The SP was not disqualified from providing direct care services as a result of the maltreatment determination in this report. However, the SP was notified by the Office of Inspector General that any further substantiated act of maltreatment, whether or not the act meets the criteria for "serious," will automatically meet the criteria for "recurring" and will result in the disqualification of the SP. The determination that the SP was responsible for maltreatment is subject to appeal.

On November 18, 2022, the facility was issued a Correction Order for the violation outlined in this report and an additional violation regarding staff training.

Certification:

The information collection procedures followed in this investigation were pursuant to Minnesota Statutes, section 260E.30, subdivision 6, paragraph (c). All individuals that are subjects of data in this investigation have the right to obtain private data on themselves which was collected, created, or maintained by the Department of Human Services.