

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: 202301068

Date Issued: May 3, 2023

Name and Address of Facility Investigated:

Little Sprouts Learning Center
500 4th Avenue SW
Sleepy Eye, MN 56085

Disposition: Maltreatment determined as to neglect of an alleged victim by two staff persons and the facility.

License Number and Program Type:

1094279-CCC (Child Care Center)

Investigator(s):

Judith Schwanke/Kim Anderson
Minnesota Department of Human Services
Office of Inspector General
Licensing Division
PO Box 64242
Saint Paul, Minnesota 55164-0242
judith.schwanke@state.mn.us
651-431-4033

Suspected Maltreatment Reported:

It was reported that an alleged victim (AV) was severely burned when a staff person (SP4) left a cup with hot water within reach of the AV.

Date of Incident(s): February 2, 2023

Nature of Alleged Maltreatment Pursuant to Minnesota Statutes, section 260E.03, subdivision 15, paragraph (a), clauses (1) and (2):

Failure by a person responsible for a child's care to supply a child with necessary food, clothing, shelter, health, medical, or other care required for the child's physical or mental health when reasonably able to do so.

Failure to protect a child from conditions or actions that seriously endanger the child's physical or mental health when reasonably able to do so.

Summary of Findings:

Pertinent information was obtained during a site visit conducted on February 9, 2023; from documentation at the facility, law enforcement records, and medical records; and through seven interviews conducted with two supervisory staff persons (SP1 and SP2), two staff persons (SP3 and SP4), the AV's family member (FM), one community person (CP2), and a health care professional (HCP).

The facility was located in a building shared with another licensed childcare center. The facility had classrooms on one side of a hallway while the other licensed center had classrooms on the opposite side of the hallway. The infant classroom was at one end of the hallway and the facility's office was on the opposite end of the hallway. Directly across the hallway from the infant room was a break room with a water cooler that dispensed hot and cold water. In the infant room was a feeding table that measured approximately 27 inches from floor to tabletop. Hanging on a wall in the infant room was a non-working landline telephone. Staff persons communicated with other staff persons using walkie talkies. In the facility office there was a facility cell phone and a walkie talkie.

The facility's enrollment documentation showed the AV was 12 months old at the time of the incident and enrolled in the facility's infant classroom.

The facility's *Injury Report Form* and *Child Care Center Serious Injury and Death Reporting Form* stated that on February 2, 2023, at 9:34 a.m., SP4 put his/her cup of hot water down on the infant feeding table. As SP4 was reaching for a tissue and SP3 was rocking an infant to sleep, the AV grabbed for the cup and hot water spilled over his/her body. First aid administered to the AV included removing the AV's clothes, immediately putting cold water all around the AV's body, applying cold rags to cover the blisters and then pressing a cold pack. The AV was also wrapped in blankets to keep him/her warm.

The AV's medical records showed that on February 2, 2023, at 9:55 a.m., the FM called the emergency room and said s/he was bringing the AV in with burns that were beginning to blister. At 10:10 a.m., the AV arrived with "significant" burns on the left arm, chest, left cheek, and right wrist and hand. The left arm had an open area, approximately 50 percent of the arm, with "blistering already peeled away" that was 7 X 7.5 centimeters (cm) long. There was a 2 X 1 cm area with blistering peeled away on the left cheek and beyond that area, more red skin on the left chin and left cheek. On the chest there was a 5 X 1.5 cm area that had blistered and peeled away, and the surrounding area was red. The right wrist had a red area with blisters that extended into the right hand and thumb area that was 4 x 2.5 cm. In total, there was a five to ten percent or greater total surface area burn. After the emergency room physician consulted with another physician, the AV was transferred by air to a specialty burn unit at another hospital.

The AV's specialty burn unit medical records showed the AV had "superficial and deep partial thickness, 2nd degree, possible full thickness burns to right arm, left face, left arm, left hand, and torso encompassing approximately 9% of total body surface area." The AV was discharged on February 9, 2023, with the FM providing wound care and future surgery for a skin graft and scarring intervention were a possibility.

The *American Heart Association Student Workbook for First Aid CPR and AED*, used when training facility staff persons, provided the following information:

- "To prevent heat burns, keep hot foods and drinks out of children's reach."
- "The only thing you should put on a burn is cool water and a clean dressing."

- “If the child has a burn, keep the child warm. If a skin burn is large, a child may not be able to control body temperature effectively. If the child gets too cold, low body temperature can develop. A healthcare professional should evaluate anyone who has burns that involve large areas of the body, the face, neck, hands or genitalia, blistering or broken skin, and difficulty breathing.”
- “For small burns, cool the burned area immediately with cold (but not ice cold) water for at least 10 minutes. If you do not have cold water, use a cool or cold (but not freezing) compress. Run cold water on the burn until it does not hurt. You may loosely cover the burn with a dry, nonstick sterile or clean dressing.”
- “For large burns, if there is a fire or the burn area is large, or you are not sure what to do, phone or send someone to call 9-1-1. Cool the burn area immediately with cold (but not ice cold) water for at least 10 minutes. After you cool the burns, loosely cover them with dry, nonstick sterile or clean bandages. Cover the child with a dry blanket. Check for signs of shock. See a healthcare provider for burns that involve large areas of the body, the face, neck hands or genitalia, blistering or broken skin, difficulty breathing.”

According to the facility’s *Parent Handbook*, “In the event of an emergency, injury, accident or illness, the Director or staff will contact the parents/guardians of the child involved. If the parent/guardians cannot be reached, staff will call the emergency contacts. If the incident is serious, staff will determine if 9-1-1 should be called. Trained staff will administer first aid if needed.”

According to the facility’s *Emergency and Accident Policies and Records and Supervision and Safety Policies*, “For a minor accident, first aid will be administered by a trained staff member and the parents/guardians are notified as mentioned above. For a major accident, requiring immediate medical attention, first aid and/or CPR will be administered by the first trained staff member on the scene and 9-1-1 will be called for emergency care.” “After calling 9-1-1, the child’s parents/guardians are contacted.” This policy also states all hazardous substances are stored out of the reach of children.

The facility’s *Risk Reduction Plan*, reviewed on February 26, 2021, lacked policies and procedures developed and implemented to minimize the risk of children being burned from hot food or beverages but referenced the facility’s existing *Accidents, Incidents and Medical Emergencies Policy* and *Supervision and Safety* policy to minimize the risk. However, burns addressed in these policies only referred to burns from the sun and there was no information regarding hot beverages. This was a violation of Minnesota Statutes, section 245A.66, subdivision 2, paragraph (d), clause (5) which states that a facility must develop a risk reduction plan that identifies risks to children that includes burns from hot food or beverages, whether served to children or being consumed by caregivers. In addition, the facility had not reviewed the risk reduction plan each calendar year which was a violation of 245A.66, subdivision 3, paragraph (b).

This investigator poured hot water from the water cooler and immediately the temperature of the water was 162 degrees Fahrenheit. Approximately two minutes later, the water temperature was 152 degrees Fahrenheit. According to the U.S. Consumer Product Safety Commission adults will suffer third-degree burns, “. . . if exposed to 150-degree water for two seconds. Burns will also occur with a six-second exposure to 140 degree water or with a thirty second exposed to 130 degree water. . . .”

The FM provided the following information:

- On February 2, 2023, at approximately 9:35 a.m., the FM received a telephone call from SP1 who stated the AV had been burned and s/he “should probably come and have him/her looked at.” SP1 told the FM that a staff person had been walking with hot water and tripped and spilled on the AV and the AV was burned from the hot water. The FM stated there was nothing in SP1’s tone to suggest the incident was an emergency. At approximately 9:40 a.m., s/he received a second telephone call from SP2. The FM could hear the AV screaming in the background and SP2 said they needed to call an ambulance. The FM told the facility not to call 9-1-1 because s/he could get the AV to the emergency room faster than waiting for an ambulance because it was only three minutes away from the facility. After the FM hung up with the childcare facility, s/he called the emergency room to make them aware they would have a burn patient coming in and to be prepared.
- When the FM arrived at the facility, s/he met SP2 and SP3 at the door. SP3 had the AV in his/her arms. The AV was wrapped in towels and wearing a poncho.
- At the emergency room, the towels were removed from the AV’s burns. The burns on the AV’s arm had blistered and the skin had peeled and was gone. The AV was transported by a helicopter to another hospital with a specialty burn unit. The AV had burns on his/her left arm, chest, right wrist, and cheek.
- As of March 15, 2023, the AV had weekly appointments at the specialty burn unit and required future laser surgery for scarring.

SP1, SP2, SP3, SP4, CP2, and the HCP, and law enforcement documentation provided the following consistent information:

- On February 2, 2023, SP3 and SP4 were working in the infant room with eight children, including the AV. SP3 was seated in a rocking chair, rocking a child to sleep, when SP4 said s/he was going to use the restroom and get water. SP3 stated that SP4 told him/her that hot water was better for him/her and drinking cold water made him/her cold. At approximately 9:30 a.m., SP3 was still rocking the child when SP4 reentered the infant classroom. SP4 walked back into the infant classroom immediately after filling the cup with hot water from the water cooler across the hall in the break room and saw the AV attempt to climb into an infant swing. SP4 placed the cup of hot water on the feeding table, which was approximately one foot away from the swing, and moved the AV from the swing and redirected him/her toward the toys nearby. SP4 noticed the AV’s nose was runny so s/he turned to get a tissue, wiped the AV’s nose, and then went to put the used tissue in the trash, which was approximately four feet away from where the cup was placed on the feeding table. SP4 heard the cup fall and saw that the AV grabbed the cup of water from the table and spilled the hot water on him/herself.
- SP3 stated the AV grabbed the cup off the table and SP3 heard water spill. SP3 and SP4 immediately began to take off the AV’s clothing and saw that the AV’s skin had begun to peel. SP3 and SP4 put cold water cloths on the AV’s burns as the AV cried and “squirmed.” SP3 used the walkie talkie to call for help from SP1 and SP2. SP1 came to the infant classroom and began to clean up the spilled water and then walked back to the office to get the facility cell phone and SP2. At 9:35 a.m., while walking back to the infant classroom, SP1 called the FM and told him/her that the AV had been burned by hot water and “I think you need to come.”
- At 9:40 a.m., SP1 saw the condition of the AV’s burns and instructed SP2 to call the FM. SP2 called the FM

and told him/her that they needed to call 9-1-1 because the AV needed to go to an emergency room. The FM told SP2 not to call 9-1-1 because the FM would be there soon.

- At 9:43 a.m., SP1 directed SP2 to call a community person (CP1) who was on the facility board and was also an emergency medical technician. CP1 advised the facility to put a blanket on the AV to keep him/her warm while putting cold towels on the burns. CP1 told a law enforcement officer that SP2 mentioned the word blister when describing the burn to CP1 but CP1 did not know the AV's skin was coming off. SP2 told CP1 that the FM was not allowing the facility to call for an ambulance because the FM thought the burn was minor. CP1 told a law enforcement officer that s/he now believed 9-1-1 should have been called before a telephone call to the FM was made.
- At 9:52 a.m., the FM called the facility to let them know s/he was close to the facility and to have the AV at the door.
- While waiting for the FM to arrive, SP2, holding the AV, and SP3 were in the hallway near a door. CP2, who worked at the other licensed center heard the AV crying "a different type of cry." CP2 asked SP2 and SP3 if they needed help and SP3 told him/her that everything was "okay." SP2 shook his/her head, "No," and stated that it was an emergency, and that the AV was burned. CP2 asked if they had called 9-1-1 and they responded, "No," because the FM did not want them to. Then CP2 asked if the HCP, who was a health care professional for the other licensed center, could come and look at the burns. The HCP then stood in the doorway to his/her office and asked SP2 and SP3 what their protocol was for emergencies and SP2 responded "to call 9-1-1." SP2 stated they had already waited approximately 20 minutes. CP2 and the HCP told SP2 and SP3 they should call 9-1-1. The HCP said that the AV's had was red but that s/he could not see the severity of the AV's injury. Then the blanket that was on the AV slipped down and CP2 and the HCP saw more of the burns on the AV's body. CP2 described the AV's left arm as "super red and skin peeled off." The HCP forcibly told SP2 to call 9-1-1. SP2 was dialing 9-1-1 when the FM arrived at 9:58 a.m. The FM came in, took the AV and left the facility.
- SP4 stated that since starting with the facility, seven months prior to the incident, s/he had brought hot water into the classroom every morning and "everyone knew" and no one had told him/her not to have hot water. SP4 did not recall being trained on not having any hot substances in classroom, but "ultimately" it was his/her fault the incident occurred. Prior to working at this childcare facility, P4 worked at the other licensed program in the building and with that program, staff persons could not drink hot beverages in the classrooms.
- The LEO asked SP1 and SP2 what the rules and regulations were regarding hot water in the infant room. Both SP1 and SP2 stated they did not believe there was a policy regarding hot water being in the room. SP1 stated s/he was not aware of any training staff persons received regarding hot beverages in the classroom and was not aware SP4 brought hot water into the infant classroom. SP2, whose first day of employment was January 30, 2023, (three days prior) stated that prior to the incident, s/he had read the facility's policy regarding incidents and accident but was not aware that the facility's *Risk Reduction Plan* was out of date and did not contain a policy regarding hot beverages in classrooms.
- SP1 also stated that s/he did not call 9-1-1 immediately because at his/her first assessment s/he thought the AV received a "small, little burn" and so s/he called the FM. SP1 stated s/he would need to review the facility's policy to know what was required for an accident but did state that if it was "severe," 9-1-1 should be called. SP1 stated s/he was not sure if 9-1-1 could be called if the FM asked them not to call 9-1-

1. SP1 stated s/he had been on the board of the facility for one year and took over the role as director when the previous director quit. SP1 said s/he was not trained for his/her role as supervisory staff.
- SP2 also stated that the staff persons in the classroom should have called 9-1-1, but there was not a telephone in the classroom and would have needed to use their personal cell phones. SP2 did not call 9-1-1 because when s/he placed a call to the FM, the FM told her not to call 9-1-1. Since the incident, SP2 advised all staff persons that no hot beverages would be allowed in the classrooms.
 - SP3 also stated that in his/her first aid training, s/he learned that hot water was hazardous and should be kept out of the reach of children. SP3 knew SP4 had water but did not know the water was hot. The facility's *Parent Handbook* stated that in emergencies, 9-1-1 should be called before family members. SP3 told others, "We need to call 9-1-1, we need to call FM," but was not sure who made the telephone calls. SP3 did not call 9-1-1 because s/he was "paying more attention" to the AV and providing immediate first aid.
 - SP4 also stated that s/he could not recall what telephone calls were made or who made the telephone calls. SP4 recalled asking SP3 what to do and whether or not they should call 9-1-1. SP3 moved the AV to the sink and was applying cold water to the AV. SP3 told SP4 s/he was unsure if s/he should call 9-1-1 or the FM and then used the walkie talkie to call SP1 and SP2. If 9-1-1 would have been called, the AV would have received medical attention sooner.

The HCP also stated that s/he was contracted by the facility to conduct training. On January 30, 2023, the HCP provided *American Heart Association Pediatric First Aid* training to SP2. At the training, the HCP and participants went through the workbook including the information outlined above.

Facility records showed that SP1, SP2, SP3 and SP4 were trained on the *Handling Emergencies and Accidents, Emergency Preparedness*, the Reporting of Maltreatment of Minors Act, and American Heart Association first aid prior to February 2, 2023.

Relevant Rules and Statutes:

Minnesota Rules, part 9503.0140, subpart 17, states that hazardous objects must be stored out of reach of children.

Minnesota Statutes, section 245A.66, subdivision 2, paragraph (e) states that the child care center risk reduction plan shall prohibit the accessibility of hazardous items to children.

Minnesota Rules, part 9503.0175, subpart 18, item D states that the temperature of hot water in the hand sinks used by children must not exceed 120 degrees Fahrenheit.

Conclusion:

A. Maltreatment:

Regarding the Incident:

Consistent information from law enforcement and SP1, SP2, SP3, and SP4, showed that on February 2, 2023, SP4 brought a cup of hot water into the classroom and left it accessible to the AV. This was a violation of Minnesota Rules, part 9503.0140, subpart 17 and Minnesota Statutes, section 245A.66, subdivision 2, (e). The AV grabbed the cup and spilled the hot water onto his/her body. The AV sustained second degree burns over nine percent of his/her body.

Although SP4 stated that s/he was never told not to bring hot water into the classroom, SP4 received training on American Heart Association First Aid which stated to keep hot foods and drinks out of children's reach. In addition, SP4 previously worked at the license program located in the same building and SP4 said that staff persons were trained that they could not drink hot beverages in the classrooms. SP4 brought the cup of hot water (likely between 152 to 160 degrees Fahrenheit) into the classroom and set it within reach of the AV. SP4 walked away allowing the AV access to the hot water, and the AV subsequently spilled it on him/herself and sustained second degree burns. Therefore, there was a preponderance of evidence that there was a failure to protect the AV from conditions or actions that seriously endangered the AV's physical or mental health when reasonably able to do so.

It was determined that neglect occurred (failure to protect a child from conditions or actions that seriously endanger the child's physical or mental health when reasonably able to do so.)

Regarding the Care after the Incident:

While SP3 notified SP1 and SP2 of the incident by walkie talkie, and SP3 and SP4 provided immediate first aid to the AV, neither SP1, SP2, SP3 nor SP4 called for 9-1-1 when they saw the AV's skin blister and peel away. Instead SP1 called the FM and according to the FM, SP1 said that the AV was burned and that the FM "should probably come and have him/her looked at." The FM stated there was nothing in SP1's tone to suggest the incident was an emergency. Although SP1 and SP2 stated that the FM said not to call 9-1-1, they did not notify the FM until the second call that the incident was an emergency and that by the time they told FM1 that they wanted to call 9-1-1, the FM was closer to the facility than an ambulance would have been.

According to the facility's *Emergency and Accident Policies and Records and Supervision and Safety Policies*, after beginning to administer first aid, a staff person will call 9-1-1 and "after calling 9-1-1, the child's parent/guardians are contacted." In addition, the *American Heart Association Student Workbook for First Aid CPR and AED*, used when training facility staff persons stated, "For large burns . . . send someone to call 9-1-1."

Failing to call 9-1-1 and calling the FM resulted in the AV not receiving professional medical care for over 35 minutes. Therefore, there was a preponderance of evidence that there was a failure to provide the AV with necessary care required and a failure to protect the AV from conditions or actions that seriously endangered the AV's physical or mental health when reasonably able to do so.

It was determined that neglect occurred (failure by a person responsible for a child's care to supply a child with necessary food, clothing, shelter, health, medical or other care required for the child's physical or mental health when reasonably able to do so and failure to protect a child from conditions or actions that seriously endanger the child's physical or mental health when reasonably able to do so.)

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.

SP1, SP2, SP3 and SP4 each had received training on the facility's policies including *Handling Emergencies and Accidents, Emergency Preparedness, the Reporting of Maltreatment of Minors Act*, and American Heart Association First Aid.

Regarding the Incident:

At the time of the incident, SP3 and SP4 were working in the infant classroom. SP3 was engaged in the care of another child. Therefore, SP3's responsibility was mitigated.

Although SP4 stated s/he was never told not to bring hot water into the classroom, SP4 received American Heart Association Pediatric First Aid training that stated to keep hot foods and drinks out of children's reach to prevent heat burns. In addition, SP4 previously worked at the license program located in the same building and SP4 said that staff persons were trained that they could not drink hot beverages in the classrooms. SP4 brought the hot water into the classroom and set it on a feeding table that was 27 inches from the floor and accessible to children.

SP4 was responsible for the maltreatment of the AV.

Regarding the Care after the Incident:

SP1, SP2, SP3, and SP4 each had a role in providing care to the AV after the incident.

Given that after the AV was burned, SP3 and SP4 each began to provide immediate care to the AV and called supervisory staff persons, SP1 and SP2, for assistance, as there was no phone in the classroom, SP3's and SP4's responsibility was mitigated.

SP1 and SP2 had significant administrative and supervisory authority over the operation of the facility and ensuring the facility maintained compliance with Minnesota Rules and Statutes. However, SP2 was in training, the incident occurred on his/her fourth day of work, and s/he was following the directions of SP1. Therefore, SP2's responsibility was mitigated.

Given that SP1 had significant administrative and supervisory authority over the operation of the facility, and that people at multiple levels failed to call 9-1-1, SP1 and the facility were 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" and whether substantiated maltreatment by a facility meets the statutory criteria to be determined as "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.

Regarding the Incident:

It was determined that the substantiated neglect for which SP4 was responsible was not "recurring"

maltreatment because it was a single incident. However, it was determined to be "serious" maltreatment because as a result of the incident, the AV sustained a serious injury (second degree burns) that required the ongoing care of a physician.

SP4 was disqualified from providing direct contact services.

Regarding the Care after the Incident:

It was determined that the substantiated neglect for which SP1, and the facility were responsible was not "recurring" maltreatment because it was a single incident of maltreatment. In addition, it was not serious maltreatment because the AV's burns were not a result of the delay in medical care.

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 policies and procedures were adequate. The facility has updated their policy to state that hot beverages are not allowed in classrooms.

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

SP1 was not disqualified from providing direct care services as a result of the maltreatment determination in this report. However, SP1 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 SP1. The determination that SP1 was responsible for maltreatment is subject to appeal.

SP4 was disqualified from a position allowing direct contact with, or access to, persons receiving services from programs, organizations, and/or agencies that are required to have individuals complete a background study by the Department of Human Services as listed in Minnesota Statutes, section 245C.03. The determination that SP4 was responsible for maltreatment and the disqualification of SP1 are each subject to appeal.

On May 3, 2023, the license holder was ordered to forfeit a fine of \$1000 as a result of the substantiated maltreatment for which facility was responsible. The maltreatment determination and the Order to Forfeit a Fine are each subject to appeal.

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.