

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: 202300825

Date Issued: June 16, 2023

Name and Address of Facility Investigated:

Teeny Bubbles Childcare and Learning Center, LLP
17140 State Highway 371
Brainerd, MN 56401

Disposition:

Allegation One: Maltreatment determined as to physical abuse of the alleged victim by a staff person.

License Number and Program Type:

1087174-CCC (Child Care Center)

Allegation Two: Maltreatment not determined.

Investigator(s):

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Suspected Maltreatment Reported:

Allegation One: It was reported that a staff person (SP) slapped an alleged victim (AV1) across the face.

Allegation Two: It was reported that a staff person (SP) spanked an alleged victim (AV2).

Date of Incident(s): January 24, 2023 and December 2022. (Note: The Minnesota Department of Human Services was made aware of allegation two on February 8, 2023.)

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 February 6, 2023; from documentation at the facility; and through eight interviews conducted with facility management persons (P1 and P2), facility staff persons (P3, P4, P5 and the SP), AV1's and AV2's family members (FM1 and FM2 respectively).

Allegation One: *It was reported that the SP slapped AV1 across the face.*

According to AV1's enrollment information, AV1 was approximately three years old and enrolled in the facility's preschool classroom.

The preschool classroom was part of a large room that was divided into two preschool classrooms.

Facility documentation, dated January 25, 2023, showed that the SP received a first warning for a "tap/slap" to a child on the cheek and that the slap "possibly" left a red mark on the AV. The documentation listed a plan for improvement that included the SP to be more aware of his/her personal self and strength and to make sure the SP was not reacting out of anger and frustration. The facility would continue to monitor the SP's reactions to children touching him/her. In addition, the documentation showed that when P2 asked AV1 what happened, s/he stated that the SP had hit him/her on the cheek.

FM1 provided the following information:

- On January 24, 2023, the SP told FM1 that s/he was "horse-playing" with AV1 and hit him/her on the cheek "accidentally." The SP said his/her hand flung around and hit AV1 on the cheek. AV1 had a "pinkish" small mark on his/her cheek on the day of the incident but the mark was gone the next day.
- AV1 had been having behavioral issues such as standing on tables and chairs, not participating in group work like cutting and tracing, running in the classroom, and not eating lunch. The facility moved AV1 into different classrooms at nap time because AV1 had trouble going to sleep and was waking other children and AV1 was separated at a table away from the other children during work time. FM1 provided resources including first/then charts and star charts that the facility used inconsistently. AV1 did not have a behavior plan but FM1 gave verbal permission to P2 to move AV1.

P3 stated that on January 24, 2023, s/he was in the preschool classroom and saw the AV1 run up to the SP and "playfully" tap the SP on the face. The SP yelled at AV1 and then slapped AV1 on the face. P3 stated that the SP's slap was not gentle and could be heard. AV1 cried and had a red mark on his/her face after the SP slapped him/her. P3 did not say anything to the SP about the incident but P3 went to AV1 and comforted him/her. The mark was there when FM1 arrived at the facility and the following day AV1 stated his/her cheek hurt. On January 25, 2023, P3 told P2 about the incident and P2 stated s/he would "look into it."

P2 was not at the facility at the time of the incident but on January 24, 2023, received a phone call from P3 who told P2 about the incident. The next day, January 25, 2023, P2 talked with P3, AV1, and the SP about the incident. P3 provided information to P2 that was consistent with the information P3 provided during his/her interview. P2 did not see a mark on AV1's face at that time but stated that AV1 by nature had "kind of" rosy cheeks. AV1 told P2 that the SP hit him/her. When P2 talked to the SP about the incident, P2 asked the SP to be more aware of his/her "personal self and strength" and to ensure s/he was "not reacting out of anger/frustration." P2 advised the SP that P2 would continue to monitor the SP's reactions to children. At the time of the site visit, AV1 was sitting alone at a table eating lunch. P2 stated that AV1 sat at his/her table for approximately the past 15 to 18

days but not for “behavior reasons but educational reasons.”

The SP provided the following information:

- On January 24, 2023, between 3:30 and 4 p.m., the children were playing with blocks and trucks and AV1 was playing with other friends. AV1 walked toward the SP and open-handed hit the SP in the face.
- The SP grabbed a toy out of AV1’s hand and then “slapped” AV1 in the face as a reaction to AV1 hitting the SP. AV1 cried after being hit and the SP told AV1, “Sorry.” After the incident, the SP turned to P3 and stated s/he did not mean to hit AV1.
- AV1 had a “red circle” mark approximately the size of a nickel on his/her left cheek. The mark lasted for “at least a couple of days,” and looked like it was bruising. The SP did not have a mark on his/her face from AV1’s hit.
- The SP explained what had happened to FM1 when FM1 came to pick up AV1.
- The SP was trained not to retaliate if bit or hit by a child. The SP said that s/he hit AV1 because she was “angry and frustrated” that AV1 had hit him/her, and that the other children were not listening.

P1 stated that s/he did not talk to any staff person about the SP slapping AV1., For the past week or two prior to P1’s interview, staff persons were monitoring AV1’s behaviors. AV1 “tended to lose [his/her] emotions, did not follow directions, and was defiant.” AV1 sat at his/her own table to “keep [his/her] body calm and to make better choices.” P1 stated it was not a “punishment” but AV1 was there most often. (Note: the facility did not have documentation regarding AV1’s behaviors or a separation log for AV1’s separation from the group.)

P4, and P5 had no direct knowledge of the incident or no longer worked at the facility at the time of the incident.

The facility’s *Behavior Guidance Policies and Procedures* contained the following information:

We maintain a positive discipline policy, which focuses on prevention, redirection, love, consistency and firmness. We stress two main patterns of behavior: respect for other people and respect for property.

Young children may hit, throw toys, bite, etc. and staff persons would attempt to prevent problems, redirect when appropriate and discuss inappropriate behaviors.

Staff persons were to ensure that each child is provided a positive model of acceptable behavior and were to teach children how to use acceptable alternatives to problem behavior.

Staff person’s prohibited actions included slapping, hitting and spanking.

Facility documentation showed that P1-P5 and the SP had received training on the facility’s *Behavior Guidance Policies and Procedures* and the reporting of Maltreatment of Minors Act.

Relevant Rules and/or Statutes:

Minnesota Rules, part 9503.0055, subpart 2 states that the license holder must have written procedures for dealing with persistent unacceptable behavior that requires an increased amount of staff guidance and time. The procedures must specify that staff:

- item A, observe and record the behavior of the child and staff response to the behavior; and
- item B, develop a plan to address the behavior in consultation with the child's parent and other staff persons and professionals when appropriate.

Minnesota Rules, part 9503.0055, subpart 3, item A, state that the license holder must have and enforce a policy that prohibits the subjection of a child to corporal punishment. Corporal punishment includes, but is not limited to, rough handling, shoving, hair pulling, ear pulling, shaking, slapping, kicking, biting, pinching, hitting, and spanking.

Minnesota Rules, part 9503.0055, subpart 4 states in part that no child may be separated from the group unless the license holder has tried less intrusive methods of guiding the child's behavior which have been ineffective and the child's behavior threatens the well being of the child or other children in the center. . . . the child must be returned to the group as soon as the behavior that precipitated the separation abates or stops.

Minnesota Rules, part 9503.0055, subpart 5 states in part that all separations from the group must be noted on a daily log.

Conclusion Allegation One:

A. Maltreatment:

Information obtained showed that AV1 demonstrated persistent unacceptable behavior. Although P1 stated that staff persons were monitoring AV1's behavior, there was no recorded observation of these occurrences, and no plan was developed to address the behavior which were violations of Minnesota Rules, part 9503.0055, subpart 2, items A and B. In addition, AV1 was required to sit at his/her own table away from the other children and these separations were not documented which were violations of Minnesota Rules, part 9503.0055, subparts 4 and 5.

Information was consistent that on January 24, 2023, after AV1 hit the SP in the face, the SP slapped AV1 in the face causing a "red" or "pinkish" mark that either gone the next day or lasted for a "couple of days." The SP's action of slapping AV1 was inconsistent with the standards of a professional caregiver in a facility licensed by the Minnesota Department of Human Services; a violation of the facility's *Behavior Guidance Policies and Procedures*; and violations of Minnesota Rules, part 9503.0055, subpart 3, item A.

Given that AV1 was three years old, that P3 heard the slap to AV1's face, that there was a mark left on AV1's cheek that FM1 stated was gone the next day, and that the SP said that s/he hit AV1 because she was "angry and frustrated" that AV1 had hit him/her, and that the other children were not listening, there was a preponderance of the evidence that the SP's actions were not accidental and caused injury or represented a substantial risk of injury.

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 was trained on the facility's *Behavior Guidance Policies and Procedures* and the Reporting of Maltreatment of Minor's Act. The SP was responsible for maltreatment of AV1.

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 or serious. It was a single incident and although the SP stated that the mark lasted a "couple of days," FM1 stated the mark was gone the next day so it was not determined whether the mark left was tissue damage or transitory in nature.

Allegation Two: *It was reported that the SP spanked AV2.*

According to AV2's enrollment information, AV2 was approximately 22 months old and enrolled in the facility's transition classroom. At the time of the incident, AV2 was in the infant classroom because it was the end of the day.

FM2 stated that on February 6, 2023, s/he received a message via Facebook from P4 which said that the SP "spanked" AV2's bottom on two different occasions in December 2022. P4 also said that s/he told P2 about the incidents. After receiving the Facebook message, FM2 sent a text message to P1 asking why AV2 was spanked. P1 told FM2 that s/he was not aware of the incidents and would talk with P2. FM2 never saw marks on AV2's bottom.

P4 provided the following information:

- There were two instances on unknown dates in early December 2022, when the SP spanked AV2 on the bottom. P4 did not recall details of the first incident, but when s/he saw the second incident, s/he thought, "Oh, that's twice."
- The second incident occurred in the late afternoon when AV2 was in the infant classroom with P4, P5 and the SP. AV2 was trying to get into a low cabinet where snacks and infant foods were stored. The SP redirected AV2 away from the cabinet, but AV2 went back to the cabinet. The SP went over to AV2 and gave AV2 a "light smack" on the bottom. The "spank" did not look "painful" but AV2 "looked very distressed" and cried for approximately three minutes. P4 also said that AV2 may have cried from the "smack" or because s/he could not have a snack. P4 did not see marks or bruising on AV2's bottom. P4 said s/he did not talk with the SP about the incident because s/he does not like confrontation.
- The morning after the second incident, P4 told P2 about both incidents. P2 already had a meeting scheduled with FM2 that evening regarding another matter so P4 told P2 s/he should bring it up to FM2 then and P2 said s/he would "make a note" and tell FM2. P4 said s/he felt relief after telling P2 about the incidents.

- After the incident in allegation one, P1 asked P4 about the incident and told P4 that P2 had no recollection of P4 telling him/her about the incidents.

P1 provided the following information:

- On February 6, 2023, P1 received a text message from FM2 asking why s/he had not been told about an incident involving AV2 and the SP. P1 did not know what FM2 was referring to but later learned that P4 knew of and the incident.
- On February 7, 2023, P1 talked with P4 who told P1 that s/he had seen the SP “firmly tap” AV2’s bottom in the infant room about one and a half months ago. P4 could not recall the dates but that it happened twice in the same week.
- P1 was unsure what to do next because the incidents happened eight to ten weeks prior. P1 did not talk with other staff persons regarding the incident because s/he left for vacation.

P2 stated s/he did not have knowledge of the SP spanking AV2 until after the incident when the SP slapped AV1. P2 stated that the SP did not get along well with other staff persons because the SP was confrontational and like to do things his/her own way and not their way. P2 did not talk to the SP about the incident, because the SP no longer worked at the facility.

P3 stated that s/he did not have any direct knowledge of the SP spank AV2 but heard it about it from other staff persons.

P5 worked with the SP in the infant and young toddler classrooms. P5 recalled seeing AV2 trying to get snacks from the cabinet in the afternoons but never saw the SP spank AV2 or any other child.

The SP said s/he recalled times when AV2 went to the snack cabinet in the late afternoon. The SP redirected AV2 away from the snack cabinet by telling AV2, “No, thank you,” and when AV2 went back to the cabinet, the SP sat AV2 down on a tape line. AV2 cried when redirected away from the snack cabinet because s/he did not get what s/he wanted. The SP denied spanking AV2 or any other child. The SP said s/he felt bullied by other staff persons but did not provide additional information.

Conclusion Allegation Two:

P4 stated that on two unknown dates in early December of 2022, P4 saw the SP spank AV2 when AV2 tried to get snacks from a cabinet which was a violation of Minnesota Rules, part 9503.0055, subpart 3, item A. P4 stated s/he told P2 about the incident but P2 stated s/he was not aware of the incidents until after the incident in allegation one, January 24, 2023. P5, who worked with the SP in the infant and young toddler classrooms, stated s/he had never seen the SP spank AV2.

Although the SP denied spanking AV2 or any child, it was possible that P4 saw the SP spank AV2 on two occasions without P5 having ever seen the SP spank any child and the SP had reason to minimize his/her actions for fear of repercussions. However, given that P4 stated it was a “light smack” or “firm tap” on the bottom that did not look “painful,” and that there was no information provided that AV2 sustained any injury, there was not a preponderance of evidence that the SPs actions represented a substantial risk of injury to AV2.

It was not 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.)

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 and followed. The SP no longer worked at the facility.

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.

Minnesota Statutes, section 260E.06, subdivision 1, requires mandated reporters at a facility to immediately report suspected maltreatment. This investigation determined that four staff persons at multiple levels of authority failed to report suspected maltreatment as required. A letter from DHS was sent to each of these individuals regarding their failure to report the suspected maltreatment and potential consequences for future such failures.

In addition, it was determined that facility mandated reporters had knowledge of the alleged incident and did not report the incident as required. The license holder was ordered to forfeit a fine of \$200 for failure to report maltreatment. The Order to Forfeit a Fine is subject to appeal.

On June 16, 2023, the facility was issued a correction order for the violations outlined in this report, failing to maintain ratios and staff distribution.

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.