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: 202303369

Date Issued: June 21, 2023

Name and Address of Facility Investigated:

New Horizon Academy
2460 Highway 100 S
St. Louis Park, MN 55416

Disposition: Maltreatment determined as to neglect of ten alleged victims by a staff person.

License Number and Program Type:

1081593-CCC (Child Care Center)

Investigator(s):

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Suspected Maltreatment Reported:

It was alleged that two staff persons (SP1 and SP2) left 10 alleged victims (AV1-AV10) unsupervised in a classroom for approximately two minutes.

Date of Incident(s): April 17, 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 April 25, 2023; from documentation at the facility; and through four interviews conducted with another child's family member (FM), a supervisory staff person (P1), SP1, and SP2.

AV1-AV10 were each three years old and enrolled in the preschool classroom. Information from all sources was consistent that SP1 and SP2 worked in the preschool classroom with AV1-AV10 at the time of the incident. AV1's-AV10's respective family members were each contacted via telephone and/or mail. Those who responded had no concerns regarding the facility.

The preschool classroom was a large square classroom with three doorways. One door, that had a push-bar lock and an alarm, led outside to a fenced in play area, a second door led to an adjoining classroom, and a third door (entrance door) led to a main hallway of the facility and had multiple lockers next to it inside the classroom. In the middle of the classroom was two rectangular tables with chairs, short bookcases, and play items that were spread throughout the classroom.

A video camera located in a corner of the preschool classroom viewed the entire classroom, including all three doors. A review of the video from the time of the incident showed the following:

- On April 17, 2023, at 8:30:17 a.m., SP1 served food to AV1-AV10 who were seated at both rectangular tables while SP2 took items out of the lockers.

- At 8:30:27, the FM and his/her child (C) entered the classroom through the entrance door and was briefly greeted by SP1 and SP2 before they returned to their respective tasks. The FM assisted the C with taking his/her coat off and then held the C. (Note: The FM did not leave the classroom.)

- At 08:31:01, a staff person (P2) entered the classroom from the adjoining classroom door and spoke to SP1 while standing in the threshold of the doorway.

- At 08:31:20, SP2 gathered the items that s/he had taken out of the lockers and exited the classroom through the entrance door. SP2 turned his/her head towards SP1 and appeared to briefly say something prior to leaving, but SP1 did not appear to acknowledge SP2 leaving the classroom and continued to serve food to the children.

- At 8:31:59, SP1 left the classroom through the adjoining doorway to the adjoining classroom and closed the door leaving the preschool children unsupervised in the classroom. SP1 did not appear to say anything or look for SP2 prior to leaving to the adjoining classroom. At this time the FM was still in the classroom with the C. At 8:32:52, the FM walked around the classroom appearing to look for a staff person in the classroom.

- At 8:33:57, SP2 entered the classroom via the entrance door and walked to the adjoining classroom door, opened the door, and appeared to talk to SP1 while standing in the threshold of the adjoining classroom doorway and shortly after SP1 came back to the classroom. SP2 then stood in the threshold of the adjoining classroom doorway and had an additional conversation with SP1, while SP1 was in the classroom.

The FM provided the following information:

- When the FM entered the preschool classroom to drop off the C, s/he saw SP1 and SP2 in the classroom and the children eating at the tables. The FM's child was having difficulty with drop off, so s/he walked him/her around the classroom.

- The FM overheard SP2 tell SP1 that s/he was leaving the classroom to take items to another classroom as SP2 walked out of the classroom. The FM did not know if SP1 acknowledged SP2's statement that s/he was leaving the room.

- The FM stated s/he did not see or hear SP1 leave to the adjoining classroom and when the FM looked for a staff person to take the C, s/he realized there were no staff persons in the classroom. AV1-AV10 were unharmed while left unsupervised by SP1 and SP2.

- The FM remained in the classroom until SP2 came back into the classroom. The FM said that when SP2 returned, SP2 told the FM that s/he was "concerned" that SP1 had left the children unsupervised. After SP2 went to the adjoining classroom doorway, the FM overheard SP2 tell SP1, "I told you I was [leaving]," but the FM did not hear SP1's response to SP2. The FM then left the facility. Later that day, the FM returned to the facility to speak to P1 about the incident.

SP1 and SP2 provided the following information:

- On April 17, 2023, SP1 and SP2 were in the preschool classroom with AV1-AV10, when the FM and the C arrived. SP1 was serving breakfast to AV1-AV10, while SP2 was gathering items to bring to another classroom at the facility.

- SP2 stated after gathering the needed items, s/he told SP1 that s/he was going to bring them to a child in another classroom. SP2 did not think SP1 gave him/her a verbal response and in hindsight, s/he should not have walked out of the classroom without a verbal response from SP1.

- SP1 stated s/he did not hear SP2 say anything about leaving. SP1 believed that SP2 was going to stay in the classroom for "a little longer" to speak to the FM.

- SP1 stated P2 from the adjoining classroom came and asked SP1 to watch his/her classroom so s/he could use the restroom. Prior to going to the adjoining classroom SP1 did not tell SP2 that s/he was going to leave the room or look for SP2 prior to leaving the room. SP1 then went into the adjoining classroom for "a minute or two" and was the only staff person in the other classroom. SP2 said that s/he did not know that P2 came to the classroom and asked to use the bathroom.

- When SP2 returned to the classroom approximately two minutes later, s/he was "stunned" because SP1 was not in the classroom. SP2 then went into the adjoining classroom and told SP1 that s/he left the children in the classroom unsupervised. AV1-AV10 were unharmed while left unsupervised by SP1 and SP2.

- SP2 stayed in the adjoining room, while SP1 returned to the classroom and SP2 returned approximately two minutes later. SP1 and SP2 then discussed the incident together. SP1 stated the conversation with SP2 was about the need to communicate more because leaving the children unsupervised was a "big no-no." SP2 stated the conversation was about the "miscommunication" that led the children being left

unsupervised, SP2 could not remember any further details of the conversation.

- SP2 stated SP1 left the classroom "right away" and told P1 about the incident. SP1 stated s/he did not tell P1 about the incident because s/he believed the FM had already done so.

P1 and facility documentation provided the following information:

- On April 17, 2023, at approximately 1 p.m., the FM came to the facility and informed P1 about the incident. P1 was not aware of the incident prior to that.

- P1 then spoke to SP1 and SP2 about the incident. Both SP1 and SP2 told P1 the children were left unsupervised in the classroom due to a "miscommunication." SP1 told P1 s/he was not aware SP2 left the classroom prior to going to the adjoining classroom.

According to the *Employee Handbook* children must have been within sight and sound of staff persons at all times and staff persons were required to maintain the staff-child ratio and staff distribution at all times. SP1 and SP2 each signed the facility's supervision and the staff-child ratio policies.

Facility documentation showed SP1, SP2, P1, and P2 each received training on the *Employee Handbook* and the Reporting of Maltreatment of Minors Act and on the facility's policies prior to the incident.

Relevant Rules and/or Statutes:

Minnesota Statutes, section 245A.02, subdivision 18, and Minnesota Rules, part 9503.0045, subpart 1, item A, stated that a child must have supervision at all times and that the supervision was defined as occurring when a staff person was within sight and hearing of a child at all times so that the program staff person intervened to protect the health and safety of the child.

Conclusion:

A. Maltreatment:

Information from all sources was consistent that on the morning of April 17, 2023, AV1-AV10 were left unsupervised in the classroom without the knowledge or supervision of a staff person for approximately two minutes, which was a violation of Minnesota Statutes, section 245A.02, subdivision 18, and Minnesota Rules, part 9503.0045, subpart 1, item A and inconsistent with the facility's policies and procedures. SP1 walked out of the classroom, unaware that the SP2 was not present in the classroom and did not ensure that another staff person was present, which was inconsistent with the standards of a professional caregiver in a facility licensed by the Department of Human Services.

Although the FM was in the classroom while SP1 and SP2 were gone, there was no staff person available to intervene had AV1-AV10 attempted to do something dangerous, had injured themselves, or in the event of an emergency. Therefore, there was a preponderance of the evidence that leaving AV1-AV10 unsupervised in the classroom while they were eating was a failure to supply AV1-AV10 with necessary care and a failure to protect AV1-AV10 from conditions or actions that seriously endangered their 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 and/or 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:
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> (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;
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> (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
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> (3) whether the facility or individual followed professional standards in exercising professional judgment.

SP1 and SP2 received training on the Reporting of Maltreatment of Minors Act and the facility's policies prior to the incident and each signed the facility's supervision policy which stated in part, "all children must be within sight and sound at all times."

At the time of the incident, SP1 and SP2 were each responsible for the supervision of AV1-AV10. Although the FM was in the classroom while SP1 and SP2 were out of the classroom it did not mitigate SP1's and/or SP2's responsibility because the FM was not a trained staff person and did not have a valid background study for the facility.

Prior to leaving the classroom, SP2 knew SP1 was in the classroom and told SP1 that s/he was leaving, which was confirmed by the FM, despite SP1 saying s/he did not hear SP2. When SP2 left the classroom, SP1 became the sole staff person responsible for the care and supervision of AV1-AV10. SP1 said that s/he did not say s/he was leaving the classroom, the FM did not hear SP1 say s/he was leaving, and SP1 failed to ensure SP2 was in the classroom when s/he left. Therefore, SP2's responsibility was mitigated and SP1 was responsible for the maltreatment of AV1-AV10.

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 lace the staff-child ratio, 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 neglect for which SP1 was responsible did not meet statutory criteria to be determined as recurring because it was a single incident that impacted ten AVs and was not serious because AV1-AV10 were uninjured.

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 conducted an internal review and determined that the policies and procedures were adequate but not followed. Staff persons were retrained on safety and supervision.

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 disqualification. The determination that SP1 was responsible for maltreatment is subject to appeal.
On June 21, 2023, the facility was issued a correction order for the violation outlined in this report.

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.