

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: 202303998

Date Issued: July 28, 2023

Name and Address of Facility Investigated:

Lil' Eagles Childcare
187 Cossairt Avenue West
Eden Valley, MN 55329

Disposition: Maltreatment determined as to neglect and physical abuse of seven alleged victims by a staff person.

License Number and Program Type:

1104019-CCCC (Certified Child Care Center)

Investigator(s):

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Suspected Maltreatment Reported:

It was reported that a staff person (SP) interacted in a manner with the alleged victims (AV1-AV7) that placed them at risk including: punishing them by making them stand in the corner and "shoving" their face into the corner hard enough to hit their head on the wall; forcing them to eat until they vomited; tipping them off their cots while they were sleeping; spanking them; and grabbing wrists and/or "dragging" the children across the classroom.

Date of Incident(s): Ongoing prior to May 19, 2023

Nature of Alleged Maltreatment Pursuant to Minnesota Statutes, section 260E.03, subdivision 15, paragraph (a), clauses (1) and (2); subdivision 18, paragraph (a); and subdivision 23, paragraph (a):

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.

"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 May 19, 2023; from documentation at the facility; and through fifteen interviews conducted with AV1, AV2, AV3, AV4, AV1's -AV7's family members, and facility staff persons.

The facility consisted of one preschool classroom located in a single occupied building.

The facility's enrollment files for AV1-AV7 showed that AV1 and AV4 were five years old; AV2, AV5, and AV7 were four years old; and AV3 and AV6 were three years old.

Initial information received by the Department of Human Services stated that there were concerns about the SP's interactions with several children. The concerns included the SP putting children in the corner facing the wall for a time out; shoving AV2's face into the wall causing him/her to hit his/her head; forcing AV1 to eat lunch until throwing up; lifting AV3's and AV6's cot to roll them off the cot and making them sleep on the floor when naptime was over; grabbing AV1's, AV3's, AV5's, AV6's, and AV7's wrist and dragging them to the corner for their time out; and spanking AV3, AV6, and AV7. Additional information stated that on an unknown date in April 2023, the SP scratched AV1's back and left mark indicating that the skin was broken during the scratch.

AV1's family member (FM1) told this investigator that sometime in the middle of April 2023, s/he noticed a scratch that had broken the skin on AV1's back between his/her shoulder blades. FM1 asked AV1 what happened and AV1 said that the SP scratched him/her because AV1 was "naughty" during circle time. AV1 did not provide FM1 with any other details. FM1 was aware that the SP was "stern" and wanted AV1 to eat everything at lunch time.

AV3's and AV4's family member (FM3) stated that AV3 told FM3 that s/he had been "spanked" by the SP and that the SP made AV3 stand in the corner facing the wall for a time out. AV3 also stated that the SP "flipped" AV3's cot up when AV3 did not wake up at the end of nap time. AV4 told FM3 that when other children were "naughty" the SP grabbed the child's wrist and "dragged" the child to the corner for time out. AV4 also told FM3 that s/he saw the SP spank other children but was not able to provide names of the children who were spanked. FM3 worked indirectly with the facility and was aware that there were concerns about the SP being too aggressive and that s/he had addressed that with a facility management person (P1) and the SP.

AV5's family member (FM4) stated that s/he knew that the SP made AV5 stand in the corner for time outs. FM4 had addressed his/her concerns with P1 and stated that s/he did not want AV5 to be put in the corner for punishment. P1 told FM4 that s/he would address it with the SP. FM4 did not have any other concerns about the care that AV5 received at the facility.

AV6's family member (FM5) stated that s/he was aware that the SP made AV6 stand in the corner for a time out. FM5 described the SP's demeanor as "direct and rude" even with family members. FM5 stated that AV6 told

him/her that the SP "hit" AV6 and made AV6 sleep on the floor instead of a cot but did not provide any other information.

Interviews with AV1-AV4, P1, and two staff persons (P2 and P3), and facility documentation and provided the following information:

- AV1, AV3, and AV4 each stated that the SP made the children stand in the corner facing the wall when they were "naughty." AV1 stated that the SP scratched AV1's back because the SP was "mad" at AV1. AV2 stated that s/he did not stand in the corner for time outs and that the SP "never" hurt him/her. AV3 and AV4 each stated that the SP grabbed AV3's and other children's wrists and dragged them to the corner when they were in trouble. AV3 also stated that the SP spanked him/her and tipped him/her off of his/her cot when s/he did not wake up after nap time.
- P1 was made aware of the concerns regarding the SP's behavior from FM1 and P2. P1 did not work on site during normal hours and was only on site when s/he was needed. When P1 spoke to the SP about the concerns regarding the SP's interactions with the children, the SP denied hurting AV1 and demonstrating any aggressive behavior toward children. In May 2023, P1 installed cameras in the facility to monitor the staff persons' interactions with the children but had not witnessed any questionable behavior from the SP.
- According to P1, prior to October 2022 when P1 started working at the facility, the SP had received re-training on not yelling and not handling the children "roughly."
- According to P2, the SP was "too aggressive" with the children. P2 witnessed the SP putting the children in the corner facing the wall for time outs; spanking AV2, AV3, and AV7; dragging children across the classroom; yelling at the children in the bathroom and at the lunch tables; and forcing AV1 to eat his/her lunch until AV1 vomited. P2 also stated that the SP pushed AV1's face into the wall when AV1 was standing in the corner.
- P2 stated that the amount of time that the children stood in the corner varied between two minutes up to forty minutes. When P2 saw the SP spank AV2, AV3, and AV7, P2 told the SP that s/he was not allowed to spank the children, and the SP responded that s/he thought they needed to be spanked. P2 stated that s/he had not observed any injury to the children.
- P2 addressed his/her concerns with P1. P2 did not always talk to the SP about the SP's interactions because when s/he addressed situations with the SP that P2 did not think were appropriate, the SP become "angry" with P2 which made the situation "awkward and uncomfortable." After P1 installed cameras in the facility, the SP "attempted to be kinder" with the children.
- P3 did not typically work with the SP but heard the SP yelling at the children on more than one occasion. P3 never witnessed the SP putting a child in the corner, spanking a child, forcing a child to eat, or dragging a child across the room.

The SP provided the following information:

- The SP stated that s/he had the children stand or sit in the corner of the room and face the wall when the child was not following directions. The SP had the child stand or sit in the corner until the child was able

to correctly tell the SP what they had done. According to the SP, the child "typically" stood in the corner for three to four minutes. The SP was not aware of a time when s/he pushed AV1's head into the wall.

- The SP stated that s/he grabbed children's hands and walked them to the corner, but that s/he did not "drag" them to the corner. If a child was still sleeping on their cot when it was time to wake up, the SP lifted the cot up so the child rolled to the floor until they woke up.
- The SP's rule at lunch time was that each child was required to eat at least two bites of their food. The SP did not force AV1 to eat their lunch, but s/he "encouraged" P1 to eat his/her "healthy" food items.
- The SP was not aware that s/he caused a scratch on AV1's neck.
- The SP spanked AV7 and an unknown child on the buttocks one time on unknown dates because they were not listening to the SP.
- The SP stated that s/he was not trained how to discipline with children at the facility.

The facility's *Policy and Procedures* stated that staff persons were to use positive techniques to guide the behavior of children by giving positive attention and appreciation, setting appropriate limits, using "no harsh" discipline methods, and helping children learn problem solving and conflict resolution skills.

The facility's personnel files showed that the SP was trained on the facility's *Policies and Procedures* and on the Reporting of Maltreatment of Minors Act on October 1, 2021. P1 and P2 were trained on the Reporting of Maltreatment of Minors Act prior to the incident. (Note: There was no documentation in the SP's file to show his/her re-training that occurred as stated above by P1.)

Relevant Rules and/or Statutes:

Minnesota Statutes, section 245H.13, subdivision 9, clauses (1) and (6) stated in part that the certified center must ensure that staff persona and volunteers use positive behavior guidance and that children are not subject to: corporal punishment, including but not limited to rough handling, shoving, hair pulling, ear pulling, shaking, slapping, kicking, biting, pinching, hitting, and spanking; and forcing of food.

Conclusion:

A. Maltreatment:

AV1, AV3, AV4, P2, and the SP each stated that the SP made children stand in the corner facing the wall when the child was "naughty" including times as long as 40 minutes. AV3, AV4, and P2 each stated that the SP grabbed AV3's wrist and "dragged" him/her to the corner. AV1 stated that the SP scratched his/her neck when the SP was "mad" at AV1. AV3 and P2 also stated that the SP spanked AV3 and tipped AV3 off of his/her cot when s/he was sleeping.

P2 stated that the SP was "too aggressive" with the children, that the SP yelled at children, forced AV1 to eat his/her lunch, and made the children stand in the corner between two to forty minutes.

Although the SP denied pushed AV1's head into the wall and stated that s/he was not aware s/he caused a scratch on AV1, the SP stated that s/he made children stand in the corner, forced AV1 to eat, tipped children off of their cots when they were sleeping, and spanked each AV7 and an unknown child one time when they were not listening.

The SP's actions were inconsistent with the standards of a professional caregiver in a program certified by the Department of Human Services and were violations of Minnesota Statutes, section 245H.13, subdivision 9, clauses (1) and (6). Given the consistent information regarding the SP's physical interactions with children, there was a preponderance of the evidence that the SP's actions were not accidental, were a failure to supply children with necessary care, a failure to protect them from conditions or actions that seriously endangered their physical or mental health, inflicted injury to a child, and threatened injuries toward multiple children.

It was determined that neglect and physical abuse 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. 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. "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 responsible for the care of AV1-AV7 at the time of the incidents. Although the SP stated s/he was not trained how to discipline with children at the facility, the SP was trained on the Reporting of Maltreatment of Minors Act prior to the incident and on the facility's *Policies and Procedures* which stated that staff persons were to use positive techniques to guide the behavior of children by giving positive attention and appreciation, setting

appropriate limits, using "no harsh" discipline methods, and helping children learn problem solving and conflict resolution skills. The SP was responsible for maltreatment of the AV1-AV7.

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 neglect and physical abuse for which the SP was responsible was serious maltreatment because AV1 sustained a scratch as a result of the SP's actions and was recurring maltreatment because there were multiple incidents by the SP involving multiple children.

The SP was disqualified from providing direct contact services.

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 Department of Human Services, Office of Inspector General:

The SP 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 the SP was responsible for maltreatment and the disqualification of the SP are each subject to appeal.

On July 28, 2023, the facility was issued a Correction Order for the violations outlined in this report, and additional violations observed during the course of the investigation, including not maintaining ratios, a center director or designee not being on site during operating hours, and 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.