DEPARTMENT OF HUMAN SERVICES

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: 202303093

Date Issued: August 11, 2023

Name and Address of Facility Investigated:

Early Explorers Child Care & Preschool, INC.
2935 13th Street South
Moorhead, MN 56560

License Number and Program Type:

1101408-CCC (Child Care Center)

Investigator(s):

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Disposition:

Allegation One: Maltreatment determined as to neglect of alleged victims by a staff person.

Allegation Two: A nonmaltreatment mistake by two staff persons to alleged victims was not maltreatment. Maltreatment determined as to neglect of alleged victims by a staff person and the facility.

Suspected Maltreatment Reported:

Allegation One: It was reported that seven alleged victims (AV1-AV7) were unsupervised for 17 minutes when a staff person (SP2) left them alone in a classroom.

Allegation Two: During the course of this investigation, it was alleged that staff persons routinely left children unsupervised in the classrooms when staff persons went to get items in another location of the facility, including:

- AV1-AV5, and another alleged victim (AV8), were unsupervised when a supervisory staff person (SP1) left them alone in a classroom on two occasions when s/he went to another classroom to get food; and
- Nine alleged victims (AV9- AV17) were unsupervised when a staff person (SP3) left them alone in a classroom to get a vacuum.

Date of Incident(s): April 11, May 1, and May 4, 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 May 4, 2023; from documentation and video footage from the facility; and through 27 interviews conducted with a health care professional (HCP), SP1, SP2, SP3, three facility staff persons (P1, P2, and P3), AV1, AV2, AV3, AV4, AV5, AV6 and AV1's-AV6's family members (FM1, FM2 FM3, FM4, FM5, and FM6 respectively) and AV7's family members (FM7 and FM8) and family members of AV11-AV17. Attempts to contact AV9's and AV10's family members were made but neither responded.

The facility cared for children ages six weeks through twelve years old. There were classrooms off each side of the entrance and lobby area. To the right of the entrance area, down a hallway, and past an alcove were the Dynamite Dinosaurs and Jungle preschool classrooms. The doorways to these two classrooms were approximately 12 feet apart. In the alcove was a storage space for nap time cots. Inside the Dynamite Dinosaurs classroom was a door with an alarm that led to the playground. On May 4, 2023, the alarm was not in working order. To the left of the entrance and down a hallway was the Out of this World preschool classroom, which adjoined the Happy Campers preschool classroom. Outside the Out of this World preschool classroom was a hallway leading another direction and a storage room. The distance between the door to the Out of this World classroom and the storage room was approximately ten feet. Each classroom and the alcove had a video camera and there were two monitors in the facility office.

According to the facility's *Risk Reduction Plan*, children were at risk of harm in a variety of ways and in order to intervene to protect the health and safety of the children, were required to be within sight and sound of a staff person at all times. The plan also stated that children could be hurt when not in eyesight both indoors and outdoors.

Facility documentation showed that P1, P2, P3, SP1 and SP2 received training on the facility's *Risk Reduction Plan* and the reporting of Maltreatment of Minors Act. Because the HCP was a contracted health care professional who did not provide direct contact services at the facility, s/he did not require a background study or training as a staff person. Therefore, the HCP was not to be unsupervised with children.

Relevant Rules and/or Statutes:

Minnesota Statutes, section 245A.02, subdivision 18 and Minnesota Rules, part 9503.0045, subpart 1, item A, state that "supervision" means a program staff person is within sight and hearing of a child at all times so that the program staff person can intervene to protect the health and safety of the child; and that children are required to be supervised at all times.

Allegation One: *It was reported that AV1-AV7 were unsupervised for 17 minutes when SP2 left them alone in a classroom.*

This investigator met AV1, AV2, AV3, AV4, AV5 and AV6 but none provided pertinent information. AV7 did not want to speak with this investigator.

FM1-FM7 provided consistent information that the facility provided them information regarding the incident on April 11, 2023.

This investigator viewed video footage, provided by the facility, of the Dynamite Dinosaurs classroom for April 11, 2023. The video was provided in ten segments and the time displayed on the video was not accurate. Segments one through nine were each nine seconds long and segment ten was five seconds long. The video segments showed three children sitting on tables, one child standing on a chair, and the HCP entering the classroom and walking around the classroom before standing near a counter at the front of the classroom. In the tenth segment, an unrecognizable staff person walked into the classroom and the video ended.

The HCP provided the following information:

- On April 11, 2023, the HCP was going from classroom to classroom and when s/he went into the Dynamite Dinosaurs classroom, s/he saw three or four children on a table with blocks and two other children standing on chairs playing with a dollhouse. The HCP completed his/her normal routine of looking at the classroom bathroom, first aid kit and posted telephone numbers and realized that SP2 was not in the classroom.

- While s/he waited for SP2 to return to the Dynamite Dinosaurs classroom, children in the classroom asked him/her where SP2 was, and the HCP replied that s/he did not know. The HCP jotted down the time s/he entered the classroom as approximately 10:50 a.m. After approximately ten minutes, P1 arrived in the classroom to deliver lunch. P1 talked with the children and then the HCP asked P1 if s/he knew where SP2 was and asked P1 to stand in the classroom. P1 told the HCP that s/he would go find SP2.

- Shortly after, SP2 returned to the Dynamite Dinosaurs classroom and did not say anything to the HCP. Then, SP2 immediately left the classroom again, went to the Jungle classroom and then again returned to the Dinosaurs classroom. At that time, the HCP left the classroom at approximately 11 a.m. The HCP did not speak with SP2.

- Hazards present to the unsupervised children of the Dynamite Dinosaurs classroom included falling off tables, exiting the classroom door and entering the playground, and exiting the classroom through the classroom door and entering the facility's other spaces.

Facility documentation and SP1 provided the following consistent information:

- On April 11, 2023, the HCP emailed SP1 and asked for a return phone call. That afternoon, SP1 called the HCP. The HCP told SP1 that while the HCP walked through the facility, s/he entered the Dynamite Dinosaurs classroom and did not see a staff person. The HCP walked through the classroom and stayed in the room for 11 minutes and during that time, P1 delivered lunch and asked if SP2 was in the classroom. The HCP told P1 that s/he did not know where SP2 was. P1 could hear SP2's voice and walked to the

Jungle classroom and "grabbed" SP2. SP2 went into the Dynamite Dinosaurs classroom and did not say anything to the HCP. The HCP then continued to walk through the facility.

- SP1 immediately checked camera footage to determine the amount of time SP2 was out of the classroom and notified another member of management. It was determined that SP2 left seven children in the classroom without staff supervision for 17 minutes (including the 10 minutes the HCP was in the classroom).

- At the end of the day, SP1 called SP2 into the office and told SP2 they needed to discuss what happened in the morning. SP2 asked SP1, "Well what happened this morning?" SP1 explained to SP2 that s/he had left the classroom and the HCP had been in the classroom for 11 minutes. SP2 stated it was not 11 minutes, signed a document, and then SP2 left the facility.

- SP1 then sent an email to FM1-FM7 explaining the details of the incident and spoke to staff persons regarding the importance of having another staff person watch the class if they had to leave the room for any reason including using the bathroom or getting supplies.

P1 provided the following information:

- On April 11, 2023, P1 went into the Dynamite Dinosaurs classroom to talk with SP2 regarding a special diet and when s/he went into the classroom, s/he saw the HCP in the classroom and children kneeling on tables. P1 asked the HCP about SP2, and the HCP replied that s/he had been in the classroom for eleven minutes and had not seen SP2.

- P1 heard SP2's voice and told the HCP that s/he would go get SP2. P1 walked to the nearby Jungle classroom and saw SP2 talking with P2 near a counter in the classroom. P1 told SP2 that the HCP had been in the class for some time and that because P1 needed to get lunch out to the children, s/he could not stay in the classroom and that SP2 needed to return. SP2 told P1 that s/he had not been out of the class for that long and walked out of the Jungle classroom and P1 went back to the kitchen.

- Prior to April 11, 2023, P1 had not seen classrooms without a staff person's supervision.

P2 provided the following information:

- On April 11, 2023, P2 replaced P3 for the day in the Jungle Classroom. The children had been good all morning so P2 was allowing the children to play games and while the children may have been loud, they were not louder than normal and did not scream or yell.

- SP2 came into the Jungle classroom and talked with P2 about other staff persons at the facility and about children not being respectful in the Jungle classroom. P2 supervised the children in the classroom while talking with SP2 because s/he did not want to be disrespectful to SP2. P1 came into the Jungle classroom and told SP2 that the HCP was in SP2's classroom and that s/he had been in the Dynamite Dinosaurs classroom for 11 minutes. SP2 "smirked" at P2 and left the Jungle classroom.

- P2 had not seen SP2 leave the classroom unsupervised before the incident.

SP2 provided the following information:

- On April 11, 2023, at approximately 11 a.m., s/he told the children in the Dynamite Dinosaurs classroom that s/he was going to check on P2 in the next room. SP2 left the door to the Dynamite Dinosaurs classroom open and the door to the Jungle classroom was open as well. The Jungle classroom was "literally four steps away" from the Dinosaurs classroom. SP2 checked in on P2 because P2 was not the usual staff person in the Jungle classroom and s/he heard the children in the Jungle classroom, and it sounded like their morning "was rough."

- SP2 said s/he could hear everything that happened in his/her classroom from the Jungle classroom and believed that if the children had needed anything they would have "yelled" for him/her.

- P1 came into the Jungle classroom and told him/her that the HCP looked for him/her and had been in the Dynamite Dinosaurs classroom for 11 minutes.

- SP2 stated time "got away" and s/he had not meant to be gone for that long.

- SP2 was trained on supervision and stated children always needed to be supervised with "eyes on" and it was never "okay to leave them unsupervised."

Conclusion For Allegation One:

A. Maltreatment

Consistent information was provided that on April 11, 2023, SP2 left children the Dynamite Dinosaurs preschool classroom unsupervised for 17 minutes while s/he went to the Jungle classroom and spoke to P2. This was a violation of Minnesota Statutes, section 245A.02, subdivision 18, and Minnesota Rules, part 9503.0045, subpart 1, item A. While SP2 was out of the Dynamite Dinosaurs classroom, the HCP walked into the room, and found AV1-AV7 without a staff person's supervision.

Although the HCP was in the classroom for approximately 10 of the 17 minutes SP2 was gone, the HCP was not a staff person with a background study and therefore was not supposed to have unsupervised contact with children. AV1-AV7 were in the Dynamite Dinosaurs preschool classroom without the supervision of a staff person for 17 minutes while SP2 visited with P2 in another classroom, which exposed them to dangers including staff persons inability to intervene to protect their health and safety as needed. Therefore, there was a preponderance of the evidence that leaving AV1-AV7 unsupervised in a classroom for 17 minutes was failure to supply each with necessary care and a failure to protect them 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 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).

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;
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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
>
> (3) whether the facility or individual followed professional standards in exercising professional judgment.

SP2 was trained on the facility's *Risk Reduction Plan* including supervision and the Reporting of Maltreatment of Minors Act. SP2 was responsible for the care and supervision of AV1-AV7 at the time of the incident. SP2 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 for which SP2 was responsible did not meet statutory criteria to be determined as recurring or serious because it was a single incident that impacted seven AVs for which AV1-AV7 did not sustain an injury.

Allegation Two: *During the course of this investigation, it was alleged that staff persons routinely left children unsupervised when staff persons went to get items in another location of the facility, including:*

- *AV1-AV5 and AV8 were unsupervised when SP1 left them alone in a classroom on two occasions when s/he went to another classroom to get food; and*
- *AV9- AV17 were unsupervised when SP3 left them alone in a classroom to get a vacuum.*

FM3 stated s/he recalled an incident that had happened approximately "a couple of months" prior to April 2023, when FM3 was picking up AV3 from the facility. When FM3 entered the Dynamite Dinosaurs classroom in the afternoon, there was not a staff person present in the classroom. FM3 took AV3 to two other facility classrooms to pick up his/her other children and returned to the Dynamite Dinosaurs classroom and there was still no staff person present. FM3 stopped in the Jungle classroom and told P3 there was no staff person in the Dinosaurs classroom. FM3 then returned to the Dynamite Dinosaurs classroom and waited, and a staff person returned and FM3 left. FM3 did not recall the staff person who was responsible for the classroom. FM3 told SP1 of this incident after learning of the incident on April 11, 2023.

FM8 stated that on the morning May 1, 2023, when s/he went into the Dynamite Dinosaurs classroom to get some of AV7's clothes, SP1 was in the classroom and then walked out of the classroom to get breakfast and was out of the classroom for approximately 30 seconds. While SP1 was out of the classroom, the children in the classroom sat at tables. When SP1 returned, s/he passed out yogurt to the children and FM8 left the classroom.

This investigator viewed the video footage from the morning of May 1, 2023, of the Dynamite Dinosaurs classroom and Jungle classroom. The video showed at approximately 8:25 a.m., SP1 and AV1-AV5 and AV8, walk into the Dynamite Dinosaurs classroom. After approximately three minutes, SP1 exited the Dynamite Dinosaurs classroom, walked through the alcove, entered the Jungle classroom and was handed a tray by P3, and returned to the Dynamite Dinosaurs classroom 20 seconds later. While SP1 was out of the classroom, two children passed out napkins, one child stood by a table, and three children sat at the tables. Approximately one minute later, SP1 again exited the Dynamite Dinosaurs classroom, walked through the alcove, entered the Jungle classroom, placed the tray on a counter next to where P3 was standing, and retrieved something else. SP1 then returned to the Dynamite Dinosaurs classroom. This incident last approximately 16 seconds. During this time, FM8 entered the classroom. In both incidents, SP1 left AV1-AV5 and AV8 unsupervised.

On May 4, 2023, while viewing the video footage at the facility for the May 1, 2023, incident, this investigator saw video feed on the facility monitors of the Out of this World classroom with AV9-AV17 and SP3 present. At approximately 3:15 P.M., SP3 walked out of the Out of this World classroom door and entered the hallway,

leaving the classroom without a staff person's supervision, while AV9-AV17 sat at tables and ate cheese and crackers. After approximately 12 seconds, SP2 reentered the classroom with a vacuum cleaner.

P3 provided the following information:

- P3 did not recall a time when a parent from the Dynamite Dinosaurs classroom came to the Jungle room and told him/her that there was no staff person in the Dinosaurs classroom and did not look for a staff person.

- On May 1, 2023, P3 was in the Jungle classroom and the children from the Jungle classroom and the Dynamite Dinosaurs were combined at this time. At approximately 8:15 a.m., SP1 came into the Jungle classroom and took the Dynamite Dinosaurs children to their classroom. P3 stated that after SP1 initially took the children, P3 did not see SP1 come back into the Jungle classroom.

- P3 said that s/he had been trained by SP1 that when a staff person in either the Dynamite Dinosaurs classroom or the Jungle classroom had to use the restroom, they were to ask the staff person in the other classroom to stand in the alcove and supervise both classrooms. P3 also stated that there was not a telephone in the Jungle classroom and if there was an emergency, s/he would take all the children with him/her out of the room or use his/her cellular telephone to call for help in the event of an emergency.

SP1 provided the following information:

- After FM3 learned of the incident on April 11, 2023, FM3 told him/her of a time when there was no staff person present in the Dinosaurs classroom when s/he picked up AV3. This was the first time SP1 had heard about this incident and FM3 did not recall the date of the incident or who the staff person was. SP1 asked P3 about this incident but P3 did not remember this incident.

- SP1 stated that on May 1, 2023, at approximately 8:15 a.m., s/he took the children enrolled in the Dynamite Dinosaurs classroom from the Jungle classroom to the Dinosaurs classroom. S/he did not bring breakfast items with and needed to go back to the Jungle classroom. The children sat at tables while SP1 left the classroom. SP1 heard but could not see the children in the Dynamite Dinosaurs classroom when s/he walked to the Jungle classroom.

- SP1 trained staff persons at the facility that if there was not a staff person available to step into the classroom for a staff person to use the restroom or grab something, they were to ask a staff person from the classroom next door to step into the alcove and supervise both classrooms. SP1 stated that "there are no other options."

- SP1 stated there was not a location in the Out of this World classroom to store a vacuum cleaner and vacuuming was to be completed at the end of the day, when children were no longer present in the classroom. SP1 stated that SP3 was not trained to leave the classroom to get the vacuum, but there were "so many teachers on their own all day."

SP3 provided the following information:

- On May 4, 2023, at approximately 3 p.m., SP3 left the Out of this World classroom to go to the utility closet in the hallway to get a vacuum cleaner. At the time of this incident, the Happy Campers

classroom's staff person and children were on the playground so SP3 did not ask another staff person to watch his/her classroom while s/he stepped out to get the vacuum. When SP3 left the classroom, the children were eating snack. When asked what s/he would do if a child choked while s/he was out of the room, SP3 said that s/he would hear them and immediately rush to help them.

- As SP3 walked to the utility closet in the hallway, s/he could not see but could hear the children in the Out of this World classroom. SP3 said s/he was out of the classroom "at most five seconds." SP3 said s/he typically walked to the utility closet at least two times per day for a mop and a vacuum. SP3 stated that s/he also left the classroom unsupervised to go into the hallway for the children's hooks and mailboxes. SP3 was not trained to leave the classroom without a staff person's supervision but thought the hallway was an acceptable distance because s/he could still hear the children in the classroom.

- SP3 provided conflicting information regarding what supervision was. SP3 stated that s/he was trained that supervision meant having eyes and ears on the children at all times, but s/he also stated that supervision meant s/he could see or hear the children but did not require both. Typically when SP3 needed to leave the Out of this World classroom, s/he asked a staff person in the adjoining Happy Campers classroom to supervise his/her room while s/he also at times provided supervision to the Happy Campers classroom by standing in the doorway between the two classrooms.

- SP3 stated that when s/he was in the classroom bathroom, s/he could hear but not see the children in the classroom.

- Hazards present to children when in a classroom without staff supervision were falling, hurting themselves, breaking something and being potentially injured by something sharp, hurting another child, choking, and leaving the classroom.

- SP3 did not know if other staff persons left classrooms unsupervised.

SP2 stated that there were times when s/he left the children in the classroom unsupervised while s/he put their cots away in the alcove. Typically if SP2 had to step out of the classroom to get something or use the bathroom, SP2 asked the staff person in the other room to watch his/her classroom.

P2 stated that staff persons in the Jungle classroom and the Dynamite Dinosaurs classroom typically left children alone in the classroom while they put cots away in the alcove outside of the two classrooms.

On August 12, 2021, the facility was issued a Correction Order that included a citation for failing to supervise. At approximately 3:34 p.m., one of two staff persons present left the classroom. "At approximately 3:35 p.m., the second staff person left the classroom, leaving 8 children unsupervised for approximately 30 seconds. Both staff persons could not be seen from the classroom or the hallway and had entered other rooms of the facility."

On September 10, 2021, the facility submitted corrective action in response to the Correction Order and signed by SP1, that stated, "An immediate conversation regarding safety and supervision was had with staff members, management team followed up with additional training for staff. This additional training and guidance from the management team will be implemented with new staff members as well."

On July 27, 2022, the facility was issued a Correction Order that included a citation for failing to supervise. "On the day of the licensing review, the DHS Licensor observed the school age teacher go inside the classroom leaving fourteen school age children alone and unsupervised on the playground for approximately one minute."

On September 13, 2022, the facility submitted corrective action in response to the Correction Order and signed by SP1, that stated, "An immediate conversation regarding safety and supervision with staff member, management team followed up with additional training for staff. This additional training and guidance from the management team will be implemented with new staff members as well."

Conclusion For Allegation Two:

A. Maltreatment

Regarding the incidents on May 1 and 4, 2023:

Consistent information was provided that there were occasions when staff persons left children unsupervised in the classroom. On May 1, 2023, at approximately 8:15 a.m., SP1 left the Dynamite Dinosaurs classroom twice leaving AV1-AV5 and AV8 without a staff person's supervision for a combined 36 seconds, while s/he walked to the Jungle classroom to get and return food. On May 4, 2023, at approximately 3:15 p.m., SP3 left the Out of this World classroom once leaving AV9-AV17 without a staff person's supervision for approximately 12 seconds while s/he retrieved a vacuum cleaner from a hallway closet. SP1's and SP3's actions were inconsistent with standards of a professional caregiver in a facility licensed by the Department of Human Services, which was a violation of Minnesota Statutes, section 245A.02, subdivision 18, and Minnesota Rules, part 9503.0045, subpart 1, item A.

Minnesota Statutes 260E.30, subdivision 3, states that rather than making a determination of substantiated maltreatment by the individual, the commissioner of human services shall determine that a nonmaltreatment mistake was made by the individual. A nonmaltreatment mistake occurs when:

> (1) at the time of the incident, the individual was performing duties identified in the center's child care program plan required under Minnesota Rules, part 9503.0045;
> (2) the individual has not been determined responsible for a similar incident that resulted in a finding of maltreatment for at least seven years;
> (3) the individual has not been determined to have committed a similar nonmaltreatment mistake under this paragraph for at least four years;
> (4) any injury to a child resulting from the incident, if treated, is treated only with remedies that are available over the counter, whether ordered by a medical professional or not; and
> (5) except for the period when the incident occurred, the facility and the individual providing services were both in compliance with all licensing requirements relevant to the incident.

Although AV1-AV5, and AV8-AV17 were in classrooms unsupervised, SP1's and SP3's actions or conduct were determined to be a nonmaltreatment mistake for the following reasons:

- At the time of the incident, SP1 and SP3 were performing job-related duties as required by the child care program plan and left AV1-AV5, and AV8-AV17 unsupervised for less than 20 seconds each time;
- SP1 and SP3 had not been determined responsible for any incident that resulted in a finding of maltreatment;

- SP1 and SP3 had not been determined to have committed a nonmaltreatment mistake under this paragraph;
- AV1-AV5, and AV8-AV17 sustained no injury during the incident; and
- Except for the period when the incident occurred, the facility and SP1 and SP3 were all in compliance with all licensing requirements relevant to the incident.

Regarding the facility's and staff persons' practice of leaving children unsupervised in classrooms:

Although the single incidents involving SP1 and SP3 met the definition of a nonmaltreatment mistake, information from all sources was also consistent that the facility's routine practice included leaving children in the classroom unsupervised while staff persons went to get items and supervising children in a manner, a single staff person outside of two classrooms, that in the event of an emergency the staff person would not be able to respond to one classroom without leaving the other classroom unsupervised.

The facility received two previous Correction Orders, (August 12, 2021, and July 27, 2022) for staff persons leaving 8 children and 14 children respectively unsupervised either in the classroom or on the playground. Each time the facility's responses were signed by SP1 and stated that they had provided "additional training for staff [persons]" and that, "This additional training and guidance from the management team will be implemented with new staff members as well."

Yet after this, more than one incident occurred again. FM3 stated that "a couple of months" prior to April 2023, s/he entered a classroom to pick up his/her child and no staff person was present. FM3 could not recall who the staff person was who eventually returned to the classroom. On May 1, 2023, SP1, a supervisory staff person, left six children unsupervised in a classroom twice, for 16 and 20 seconds respectively. On May 4, 2023, SP3, left nine children unsupervised in a classroom for 12 seconds. SP3 also stated that s/he typically walked to the utility closet at least two times per day leaving the children unsupervised in the classroom and left the classroom unsupervised to go into the hallway for children's hooks and mailboxes. SP2 and P2 each stated that there were times they left children in the classroom unsupervised while each put cots away in the alcove.

In addition, SP1 stated that s/he trained staff persons that if a staff person needed to get something or use the bathroom, a staff person from another classroom supervised two classrooms from the alcove, or by standing outside each room and watching both rooms. SP1 stated that "there are no other options." P3 stated s/he was trained as such by SP1, and SP2 and SP3 each provided information regarding supervising two classrooms from the hallway that was consistent with what SP1 and P3 stated.

These incidents of children being unsupervised were violations of Minnesota Statutes, section 245A.02, subdivision 18, and Minnesota Rules, part 9503.0045, subpart 1, item A. Given that information from FM3, SP1, SP2, SP3, P2, and P3 was consistent that after the Correction Orders dated August 12, 2021, and July 27, 2022, and the facility's corrective action (September 10, 2021, and September 13, 2022) of "additional training and guidance" for staff persons including "new staff members as well," the facility allowed and staff persons continued to routinely and likely daily leave children in classrooms unsupervised and supervised children in a manner that in the event of an emergency, a staff person would not be able to respond to one classroom without leaving the other unsupervised. Therefore, there was a preponderance of the evidence that routinely leaving children unsupervised in the classrooms, including times when they are eating, were a failure to supply children including AV1-AV5, AV8, and AV9-AV17 with necessary care and a failure to protect them 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 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).

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.

Regarding the facility's and staff persons' practice of leaving children unsupervised in classrooms:

SP1 had significant administrative and supervisory authority over the operation of the facility and maintaining compliance with Minnesota Rules and/or Statutes. SP1 stated that s/he trained staff persons that if a staff person needed to get something or use the bathroom, a staff person from another classroom supervised two classrooms from the alcove, or by standing outside each room and watching both rooms. SP1 stated that "there are no other options." SP1 was trained on the facility's *Risk Reduction Plan*, and the Reporting of Maltreatment of Minors Act. SP1 was responsible for the neglect of children, including AV1-AV5, and AV8-AV17.

In addition, given SP1's role at the facility and that staff persons from multiple classrooms, at multiple levels of authority left children in the classroom unsupervised while staff persons went to get items and supervising children in a manner, a single staff person outside of two classrooms, that in the event of an emergency the staff person would not be able to respond to one classroom without leaving the other classroom unsupervised, the facility was also responsible for the maltreatment of children, including AV1-AV5, and AV8-AV17.

C. Recurring and/or Serious Maltreatment:

The Office of Inspector General is required to evaluate whether substantiated maltreatment by a facility meets the statutory criteria to be determined as "serious" and 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 for SP1 and the facility was responsible did not meet statutory criteria to be determined as serious because there was no information that any child sustained an injury. In addition, the neglect was not recurring because it was the pattern of lack of supervision which represented a single incident.

Action Taken by Facility:

The facility completed an internal review and determined that policies and procedures were not adequate and not followed. The facility has implemented new policies, retrained staff persons, and installed new telephone devices in some classrooms. SP2 no longer worked at the facility.

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

SP1 and SP2 were not disqualified from providing direct care services as a result of the maltreatment determination in this report. However, SP1 and SP2 were each 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 or SP2. The determination that SP1 and SP2 were responsible for maltreatment is subject to appeal.

SP3 was not determined as a perpetrator of maltreatment of AV9-AV17 because the Department of Human Services found that the incident for which SP3 was responsible met the criteria to be determined a

nonmaltreatment mistake. SP3 was notified by the Office of Inspector General that any future incident of possible neglect of an alleged victim for which SP3 is responsible might not be considered a nonmaltreatment mistake.

On August 11, 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.