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: 202302484

Date Issued: August 18, 2023

Name and Address of Facility Investigated:

New Horizon Academy
2204 Lower Afton Road
Saint Paul, MN 55119

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

License Number and Program Type:

801677-CCC (Child Care Center)

Investigator(s):

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Suspected Maltreatment Reported:

It was reported that a staff person (SP) grabbed and pulled two alleged victims (AV1 and AV2) and as a result, AV1 received an injury near his/her eye.

Date of Incident(s): March 17, 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 April 3, 2023; from documentation at the facility; and through eight interviews conducted with AV1, AV2, a facility supervisory staff person (P1), four staff persons (the SP, P2, P3, and P4), and AV1's family member (FM1). Attempts were made via email to contact and interview a staff person (P4) but the attempts were not successful. Attempts were also made via phone and U.S. mail to contact and interview AV2's family member (FM2) but the attempts were not successful.

AV1 and AV2 were approximately three and a half years old at the time of the incident and enrolled in the pre-K classroom.

FM1 and a photo taken by FM1 of the injury provided the following information:

- On March 17, 2023, at pick up, AV1 told FM3 that the SP had "scratched" his/her face. The facility had an incident report which said that AV1 "just woke up with a scratch under [his/her] eye." This concerned FM3 that the incident report was not "accurate" and FM3 told the facility that they needed to look at the cameras to "know what happened" because AV1 was saying that the SP caused the scratch.

- FM1 then took a photo of the injury on March 17, 2023, and the photo showed that AV1 had an approximately half inch red mark under his/her right eye. FM1 applied "antibiotic ointment" for the scratch but AV1 did not need to go to the doctor.

- At some point, P1 told FM1 that they viewed video footage which showed that during nap, P4 "handed" AV1 to the SP who then "grabbed [AV1] roughly" and the SP's ring scratched AV1. The SP wore a "lot of rings."

- FM1 had concerns that staff persons were not trained on how to work with children. Additionally, the facility, including P1, "never apologized" to FM1 about the incident.

- Approximately two months prior to the incident, AV1 had a "spike" in "behaviors" which FM1 thought was due to "family changes." Because of this, the facility "probably was not used to [AV1] not listening."

AV1 said that a "teacher was being bad" but did not provide any examples of what the teacher did. AV1 did not know the teachers name but said that they were the opposite gender as the SP. AV1 also said that s/he and other children did not take naps at the facility.

AV2 said that there were no teachers that s/he did not like. AV2 did not have any concerns with the facility.

P1 and the *New Horizon Academy Internal Review Form* completed by a supervisory staff person (P6) provided the following information:

- On March 17, 2023, around 3 p.m., P3 told P1 that AV1 woke from nap with a "scratch" under his/her eye (P1 did not remember which eye but it was later determined that it was AV1's right eye). P1 then saw the injury and said it looked like a "scrape." AV1 did not receive any medical attention for the scratch/scrape.

- P1 then spoke to all the staff persons who were in the room with AV1 during nap. This included the SP, P3, and P4. The SP, P3, and P4 were not aware of how AV1 received the scratch/scrape and did not recall seeing the scratch/scrape on AV1 prior to nap. The SP, P3, and P4 also said that AV1 did not cry during

nap.

- P1 also spoke to AV1 but had a "hard time" understanding AV1 due to not spending a lot of time with AV1. Additionally, during pick up, AV1 said something about the injury to his/her family member (FM3) but P1 could not understand what AV1 said.

- Later, on March 17, 2023, FM1 sent "human resources [at the facility corporate office]" and P1 an email stating that AV1 returned home from the facility with a scratch under his/her eye that AV1 said happened at nap time. FM1 said that AV1 told him/her that the SP was the "one that scratched [him/her]." FM1 wanted to know how AV1 received the scratch and said that AV1 would not have done it to him/herself.

- On March 20, 2023, P1 and P6 watched video footage of the incident (which this investigator also viewed). The video showed that during nap, the SP sat on the floor between two cots. P4 was doing "most of the work gathering the children and getting them on their cots." The SP was "not doing [his/her] share of helping to attend to the students." However, the SP was "shouting [and] yelling out directions" to the children in the room (Note: The video did not have sound but P1 said that other staff persons said the SP did so).

- The video also showed "two interactions" by the SP that "did not align" with the facility behavior guidance policy. The "first unacceptable major interaction" with the SP was with AV2. AV2's cot was in front of where the SP was sitting. AV2 was "standing on [his/her] cot and appeared to not want to get on [his/her] cot." (Note: This investigator did not see AV2 standing on his/her cot or refusing to get on the cot but P6 said that AV2 was doing so prior to what the video footage that the facility sent this investigator showed.) The SP then "pointed" to AV2 and "directed" AV2 to come to the SP. AV2 then "slowly and with hesitation" walked towards the SP. The SP then "abruptly [and] aggressively grabbed" AV2 by AV2's arm. (Note: This investigator viewed AV2 with a blanket around his/her shoulders and AV2 was holding the blanket around him/her. This investigator was not able to tell if the SP grabbed AV2 by the blanket or if the SP also grabbed AV2's arms, which were under the blanket.) The SP then "pulled" AV2 towards the SP, close to the SP's face. During this interaction, the SP "closed hand punched [AV2] on the forehead." (Note: This investigator was unable to tell if the SP's fist struck AV2 or if the SP's fist/hand went near AV2's face without making contact.) AV2 "immediately" began crying. (Note: AV2 was not crying prior.) The SP then "scolded" AV2 and pointed towards AV2's cot. The SP let go of AV2's arm and AV2 walked to his/her cot while still crying. There were no known injuries to AV2.

- The second "unacceptable major interaction" occurred with the SP and AV1. This interaction was "very similar" to the interaction with AV2, including that the SP was sitting on the floor between two cots and AV1 was on a cot in front of the SP. Video footage showed that AV1 did not want to go to his/her cot. (Note: When this investigator viewed the footage, AV1 was on his/her cot but was moving around. However, P1 said that prior to this, AV1 was "actively moving around the room and not settling down," including jumping on furniture.) The SP then "directed" AV1 by pointing at AV1 to come to the SP. (Note: This investigator viewed AV1 sitting on his/her cot and P4 walking towards AV1. P4 then lifted AV1 underneath his/her arms and carried AV1 towards the SP, who was only a couple feet away. There was no indication that P4 touched AV1's face.) The SP then "abruptly [and] aggressively grabbed" AV1 (by AV1's left arm) and placed AV1 between the SP's legs on the floor. The footage showed AV1 crying and rubbing his/her face underneath his/her (right) eye. The SP "did not seem to care" that AV1 was crying

  and did not look at AV1 to see why s/he was crying. AV1 was not crying prior to his/her interaction with

the SP. (Note: The video footage ended so did not show how long the SP sat with AV1.)

- P1 thought that the SP may have scratched AV1 "unintentionally" with one of his/her rings during the aforementioned interaction. The SP typically wore "quite a few rings" on both hands, including those with "settings" that were "higher up."

- When this investigator asked P1 if there were any prior concerns with the SP, P1 said that the SP typically had a "loud" and "harsh" voice, including when interacting with children. Supervisory staff persons had spoken to the SP prior about his/her "tone" and reminded the SP that they were "just children."

P3 provided the following information:

- On March 10, 2023, around 1:15 p.m., (approximately one week prior to the incidents above) AV1 was "jumping around" on the cots and did not want to nap so the SP "grabbed" AV1 and "threw" AV1 in the "air" onto the cot. The SP also "slapped" AV1. P3 was "sad" when s/he saw this because AV1 did not do "anything wrong." P3 asked AV1 if s/he was "fine" and AV1 said that s/he had a "headache," which P3 did not recall AV1 having prior. P3 put a "cool rag" on AV1's neck and AV1 fell asleep. P3 did not see any injuries to AV1. There were no other staff persons in the classroom during this incident. (Note: The facility did not have video footage from this date as the footage only saved for seven days. Additionally, no other staff person, including P1, was aware of this incident).

- When this investigator asked P3 what s/he did when s/he saw these things, P3 said that s/he "did not really say anything" and also "walked away." P3 was "scared" to say anything because a supervisory staff person (P5) was the SP's family member. However, when another incident occurred with the SP, P3 told P1. This included that on a different date on a "Friday [later determined to be March 17, 2023]," P3 worked in AV1's and AV2's classroom. Around 11 or 12 p.m., the SP came into the classroom to assist with nap and provide breaks for the staff persons. Around this time, P3 assisted the children, including AV1, with lying down on their cots to get ready for nap. During this time, AV1 had a toy and was hitting other children with it so P3 took the toy from AV1 and told AV1 that s/he would put it on AV1's cot once AV1 was asleep. P3 then left the classroom to assist children in another room while the SP and P4 remained in AV1's and AV2's classroom. When P3 left, AV1 was "lying down and not bouncing around" and did not have a "mark" on his/her face.

- After nap, around 3:15 p.m., P3 came into AV1's classroom and noticed that AV1 had a half inch to one inch "cut" under his/her right eye. AV1's eyes were also "poofy" and P3 assumed AV1 had been crying. P3 asked AV1 if s/he "cut [him/herself] in [his/her] sleep" or hit him/herself on his/her cot. AV1 said, "No." P3 then asked AV1 how s/he got the "cut" and AV1 said that the SP "did it." P3 asked AV1 how the SP caused the "cut" and AV1 said that the SP "hit" him/her. P3 asked AV1 "four more times" to see if AV1 would "change [his/her] answer" but AV1 did not. P3 "kept asking" AV1 because s/he did not want to "believe" the SP caused the injury but P3 knew "deep down in [his/her] heart" that the SP caused it. The "cut" was "kind of bleeding" so P3 told P1 who told P3 to "wash the wound," which P3 did. The cut then "scabbed up." P3 thought that the "cut" was from a ring on the SP's finger because the SP wore "about seven rings."

- Around 5:45 p.m., FM3 arrived at the facility to pick up AV1. FM3 saw the cut and asked AV1 what

happened and AV1 said that the SP "hit" him/her. P3 could understand AV1 "clear as day" when AV1 told FM3 that the SP caused the cut.

- At some point, P3 spoke to P4 who said that s/he was in the classroom with AV1 and the SP at the time of the incident. P4 told P3 that s/he heard the SP "yell" at AV1. P4 could also hear AV1 "running around" and said that the SP "grabbed [AV1] and put [AV1] down."

- P3 was not aware of the SP doing anything to AV2 on March 17, 2023. However, prior to P3 leaving the classroom during nap, AV2 told P3 that his/her arm (P3 did not recall which arm), "hurt." P3 asked AV2 what s/he "meant" and AV2 said that s/he was "pulled" near his/her shoulders but did not say by who. P3 saw that AV2's arm was "red" but did not see any injuries.

- Additionally, at some point prior on an unknown date, during playtime, P3 saw the SP "grab" AV2 by his/her upper arm and "pull [AV2] around" to sit in a chair because AV2 was not sitting. However, P3 said it was playtime and children did not need to sit.

- The SP "went after [AV1] the most." P3 thought that the SP interacted this way with AV1 because AV1 was "more of a trouble kid." AV1 was also a "little harder" to get down during nap and staff persons needed to "pat" AV1's back.

- According to P3, "almost everyone" talked to the SP about his/her interactions. P2 also told P3 not to leave AV1 or other children "alone" with the SP. P3 would "constantly get headaches" from the SP yelling at the children.

- If P3 needed a break from children, s/he would go to another part of the room. However, P3 had never seen the SP do so.

P4 said that on the date of the incident (P4 did not recall the date) during naptime, s/he was working with the SP. AV1 was "not listening" so the SP, who was seated and assisting other children, asked P4 to "give [AV1] to [the SP]." The SP was sitting "so close" to where AV1 and P4 were so P4 "held" AV1 and "brought" AV1 to the SP and then AV1 sat in the SP's lap. P4 did not recall how s/he held AV1 but said that s/he did not touch AV1's face. P4 then "turned" to help another child and heard AV1 crying. P4 did not recall if AV1 was crying prior. P4 "looked back" towards the SP and AV1 but "did not see anything" aside from AV1 sitting in the SP's lap. P4 did not see any injuries to AV1 prior to nap or after nap and did not know how AV1 sustained the injury. P4 did not recall the SP interacting with AV2 on the date of the incident. P4 did not have any concerns with the SP's interactions with children, including on the date of the incident. P4 would feel comfortable reporting if s/he had concerns. Additionally, P4 would be comfortable having the SP work with his/her own children.

P2 provided the following information:

- P2 was not at the facility on March 17, 2023, when the incidents with AV1 and AV2 occurred. However, P2 had concerns with the SP's interactions with children in general. This included that the SP "yelled" at the children "a lot." Additionally, the "words that came out of [the SP's] mouth" were "not very nice." The SP told the children to "shut up [and] sit down" and "things that [staff person's] weren't supposed to say to children."

- The SP also had a "personal vendetta" against AV1 and would "constantly holler" at AV1. AV1 needed

"structure and love" but the SP did not give AV1 "love." Because of this, P2 told other staff persons to keep the SP "away" from AV1.

- P2 was not aware of the SP causing injuries to children, aside from AV1 (which P2 was not present for).

- At some point, P2 spoke to the SP about his/her interactions and the SP "did not like it" and had an "attitude." P1 and P5 were also aware of the concerns as P2 did not keep his/her "mouth shut" and told them. When this occurred, P5 talked to the SP and things changed "for a day." Other staff persons also told P1 and P5 about the concerns. When this investigator asked P2 which staff in particular had concerns with the SP's interactions with children, P2 said, "Everyone."

- P2 thought that the SP was "stressed out." The SP was not a "bad person" but was "frustrated." This included due to staffing as there were no additional staff persons to help if a staff person needed a break as the supervisors (P1 and P5) were usually in classrooms.

The SP provided the following information:

- The SP was told by the facility that on March 17, 2023, s/he "apparently scratched a child." The SP initially told this investigator that s/he did not know which child but later said that s/he was told by the facility that it was AV1. The SP "could not believe" s/he caused a scratch to a child and never saw any child with a scratch. Additionally, no children said they were hurt. The SP said that video footage would not show the SP scratching or injuring a child.

- The SP said that March 17, 2023, was a "pretty chaotic" and "very stressful" day because there were 26 children with the SP, P4, and another staff person, whose name the SP did not recall but was later determined to be P3. Prior to nap, the SP set out the cots. However, the SP had some health issues which the facility was aware of so putting out the cots was "not the easiest task in the world." There were not enough cots, so at some point, P3 took five of the children (including AV2) to another room where they remained with P3 during nap.

- At some point, the SP was sitting between two children who would not nap and was rubbing their backs. AV1's cot was in front of the SP. AV1 was a "bundle of energy" but only a "little bit more" than other children. This included that AV1 was dancing on top of a table during nap. (Note: Video footage that this investigator viewed did not show this, although P6 said that around this time, AV1 was climbing on a child sized couch.) The SP then had AV1 "come over" and sit on his/her lap. The SP did so by getting up on his/her knees and "helping [AV1] towards [the SP]." The SP talked to AV1 about what s/he should do differently and then asked AV1 to lay on his/her cot, which AV1 did.

- The SP did not see any scratch on AV1 but thought that AV1 would be accurate regarding stating where s/he got the scratch. The SP also said that if AV1 said the SP caused the scratch, then the SP may have done so "accidently." The facility later told the SP that video footage showed that when the SP was "helping" AV1, that the SP scratched AV1 with one of his/her rings. The SP wore rings on both hands and one ring was "raised a little." The SP felt "extremely horrible" about the incident and thought that AV1 and the SP started and ended the day on a "good note."

- The SP did not recall P4 assisting AV1 during nap and did not know if P4 could have caused the scratch.

The SP did not have any concerns with P4's interactions and said that P4 was "way more calm" than the SP. The day was not "perfect or smooth" and the SP and P4 tried to "do what they could to get through the day."

- At some point during nap, the SP was moved to the school age room. The SP denied touching AV2, despite "someone" who the SP did not recall, saying s/he did. The only interaction between the SP and AV2 was that the SP asked AV2 to "lay down." The SP did not recall grabbing and pulling AV2 forward and did not know why the video footage showed the SP doing so. The SP did not recall AV2 crying. At some point during nap, AV2 was moved to the other room with P3.

- The SP said that there were no other concerns during the 15 years that s/he worked at the facility, including that no supervisory staff person ever talked to the SP about concerns. The SP described him/herself as "positive" with the children. The SP denied yelling at children but said that s/he was a "loud person" and used a "loud voice" with children. The SP typically worked with P4 in AV1's and AV2's classroom which had children with "high behaviors." When children displayed behaviors, the SP would redirect the children or give them a toy. The SP also talked to the children. During nap, the SP rubbed children's backs or turned quiet music on.

- The facility was starting to work on a behavior plan for AV1 due to AV1 throwing things such as chairs or toys at other children. However, AV1 did not have one at the time of the incident. AV2 was typically a "easy going" child.

- The SP did not recall telling a child to shut up but if s/he did, it was "probably to try and settle down the room." It would "absolutely not" be appropriate to do that. Staff persons were also trained never to rough handle a child.

The *Behavior Guidance Policy* said that when a child displayed behaviors, staff persons were to offer "help" to the child, modify the child's environment, and give children choices. The *New Horizon Academy Prohibited Regulations* said that rough handling, pulling arms, hitting, shoving, and pinching were "prohibited." The *Family Handbook* said that the facility was a "family-friendly" place where children received "high quality care" in a "peaceful and loving environment." Any behavior towards children that was deemed "inappropriate" was not "tolerated."

The *New Horizon Academy Mandated Reporting Sign-Off for Employees* said that if a staff person suspected a co-worker of "abuse," then they were to report to the "in-center maltreatment phone number" which was posted near each phone. The *Maltreatment of Minors Mandated Reporting* said that this included "physical abuse."

Facility documentation showed that the SP, P1, P2, P3, and P4 each received training on the Reporting of Maltreatment of Minors Act, and on the facility's policies, including behavior guidance, prior to the incident.

Relevant Minnesota Statutes and Rules:

Minnesota Rules part 9503.0055, subpart 3, item A, states 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.

Conclusion:

A. Maltreatment:

On March 17, 2023, video footage from the facility showed that during nap, the SP "abruptly [and] aggressively grabbed" AV1. The footage showed that after this interaction, AV1 was crying and rubbing his/her face underneath his/her (right) eye. After nap, a scratch/scrape was observed under AV1's right eye. Information was consistent that prior to nap, AV1 did not have the scratch/scrape under his/her right eye. AV1 was also not crying prior to his/her interactions with the SP. AV1 told FM1, FM3, and P3 at different times that the SP caused the scratch/scrape. P3 said that AV1 told him/her that the SP caused the injury when the SP "hit" AV1.

Although there were no known injuries to AV2, video footage also showed that the SP "abruptly [and] aggressively grabbed" AV2 by AV2's arm, "pulling" AV2 towards him/her, close to the SP's face. According to the *Internal Review Form*, the SP "closed hand punched [AV2] on the forehead" but this investigator was unable to tell if the SP's fist struck AV2 or if the SP's fist/hand went near AV2's face without touching it. AV2 "immediately" began crying when s/he was not crying prior. P3 also said that prior to leaving the classroom during nap, AV2 told P3 that his/her arm (P3 did not recall which arm), "hurt." P3 asked AV2 what s/he "meant" and AV2 said that s/he was "pulled" near his/her shoulders but did not say by who. P3 saw that AV2's arm was "red" but did not see any injuries.

P2 and P3 also had prior concerns with the SP's interactions with children, including that the SP "grabbed" AV2 by the arm prior and told children to "shut up [and] sit down" and "things that [staff person's] weren't supposed to say to children."

Although the SP denied his/her interactions with AV1 and AV2, the SP had reason to minimize his/her interactions for fear of repercussion and the SP's actions as shown in video and described by P2 and P3 was consistent that the SP handled children in a physically aggressive manner. The SP's conduct of grabbing children "abruptly and aggressively" was inconsistent with the standards of a professional caregiver in a facility licensed by the Department of Human Services; was a violation of the facility's behavior guidance policy and procedures; and a violation of Minnesota Rules, part 9503.0055, subpart 3, item A. Given that AV1 and AV2 were approximately three years old at the time of the incident and started crying after their interactions with the SP, and that AV1 sustained a scratch/scrape under his/her eye and was favoring this area after his/her interactions with the SP, there was a preponderance of the evidence that the SP's actions were not accidental, caused injury to AV1 and represented a substantial risk of injury to AV2.

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 responsible for AV1's and AV2's care and supervision at the time of the incident. The SP was trained on the facility's policies, including the Behavior Guidance policy and the Reporting of Maltreatment of Minors Act.

The SP was responsible for maltreatment of AV1 and AV2.

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 was not recurring because the SP's pattern of behavior was considered a single incident but was serious because AV1 sustained a skin laceration/tissue damage.

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 Facility:

The facility completed an internal review and determined that policies and procedures were adequate but not followed by the SP, including the behavior guidance policy. There were no similar concerns with the SP. However, the SP had been at the facility for approximately 20 years and was a "no nonsense" staff person. Over the years, staff persons "redirected [the SP's] style of teaching" but at no times had staff persons seen the SP "hurt" a child. The "unacceptable interactions" between the SP and AV1 and AV2 that were witnessed on the video footage and "all the years of training" that the SP received on the "proper manner" to re-direct and guide children, left the facility with "certainty" that the facility would "not allow" the SP to continue working at the facility so therefore, the SP no longer worked at the facility.

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 August 18, 2023, the facility was issued a Correction Order for the violation outlined in this report and for exceeding the allowable number of children in the pre-k room.

Additionally, Minnesota Statutes, section 260E.06, subdivision 1, requires mandated reporters at a facility to immediately report suspected maltreatment. The investigation determined that one staff person failed to report suspected maltreatment as required. A letter from DHS was sent to this individual regarding his/her failure to report the suspected maltreatment and potential consequences for future such failures.

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.