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: 202304165

Date Issued: August 18, 2023

Name and Address of Facility Investigated:

Tutor Time of Apple Valley
14370 Glenda Drive
Apple Valley, MN 55124

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

License Number and Program Type:

810112-CCC (Child Care Center)

Investigator(s):

Anna Parkin
Minnesota Department of Human Services
Office of Inspector General
Licensing Division
PO Box 64242
Saint Paul, Minnesota 55164-0242
anna.parkin@state.mn.us
651-431-6225

Suspected Maltreatment Reported:

It was reported that a staff person (SP) picked up an alleged victim (AV) by one arm and then threw a ball at the AV's head.

Date of Incident(s): May 15, 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 24, 2023; from documentation and video footage at the facility; and through six interviews conducted with a supervisory staff person (P1), two facility staff persons (P2 and the SP), a community person (CP), and the AV's two family members (FM1 and FM2).

According to the AV's enrollment information, the AV was 25 months old and in the toddler room at the time of the incident. The facility had two outside playgrounds that included a toddler playground and a preschool playground. Near the playground was a community building and parking lot.

The CP provided the following information:

- On May 15, 2023, at approximately 3:20 p.m., while the CP sat inside a vehicle in the community parking lot, s/he noticed two staff persons and children outside on the toddler playground. A staff person (later determined to have been the SP) walked over to two children (the AV and another child) who had a toy. The SP picked up the AV by one arm and "plopped" him/her down on the ground.

- The SP then walked back near the building and spoke to another staff person (later determined to be P2). The AV and the other child went back to playing with each other. The SP again walked over to the AV, raised a ball above the SP's head, and "slammed it with force" on the AV's head. The CP stated it was thrown at the AV's head on purpose. The ball was a larger plastic one used on the playground. The SP then walked away from the AV. The CP had to pay attention to what s/he was doing so did not see the AV's reaction. Later on, the CP contacted the facility's cooperate office.

Video footage provided by the facility showed a majority of the toddler playground. In the video, the AV and another child were pulling on a toy. The SP walked over, used one hand to pick up the AV by one arm, and the AV landed in a sitting position on the grass. The AV stood up and walked away. The SP was interacting with the AV and the other child for a short time before walking away. Approximately one minute later, another child handed the SP a ball. The SP quickly walked back to where the AV was. The SP lifted the ball above his/her head with one hand and threw it with force at the AV. The SP's body was blocking the view of the AV so it is not known if the ball hit the AV but it bounced to the opposite side as if it hit something. The SP walked over and picked up the ball and pointed at the AV. The SP stood and spoke to the AV when the video ended. P2 was either facing away from the AV or out of the view of the camera during that time.

The SP stated on the day of the incident, P2 and the SP were outside with children on the toddler playground. The AV was crying and the SP threw the ball with one hand at the AV thinking the AV would stop crying and play with the ball. The SP denied that the ball hit the AV on the head.

P2 did not see anything unusual or concerning with the SP and the AV on the playground on the day of the incident. P2 did not have previous concerns with the SP's interactions with children.

P1 stated in the morning of May 16, 2023, s/he received a phone call from the cooperate office about the

incident. P1 watched the video and then spoke to the SP who denied the incident. The SP denied the interactions between the SP and the AV. The SP told P1 that it was possibly a different staff person on the video and not the SP. P1 stated based on the video s/he saw, s/he identified the SP in the video. P1 did not have any previous concerns with the SP. Later that day, P1 saw the AV and did not see any injuries or marks on the AV.

FM1 and FM2 were not aware of the incident prior to talking to this investigator. FM1 and FM2 did not see any injuries on the AV around the time of the incident and did not have previous concerns with the facility.

According to the facility's *General Professional Conduct* policy, staff persons created a "warm, nurturing, and safe environment" for the children.

Facility documentation showed that staff persons, including the SP, received training on the facility's *General Professional Conduct* policy and the Reporting of Maltreatment of Minor's Act prior to the incident.

Relevant Rules and/or Statutes:

Minnesota Rules, part 9503.0055, subpart 3, item A, states that the license holder must have and enforce a policy that prohibits the following actions by or at the direction of a staff persons: Subjection of a child to corporal punishment, which includes, but is not limited to, rough handling, shoving, hair pulling, ear pulling, shaking, slapping, kicking, biting, pinching, hitting, and spanking.

Conclusion:

A. Maltreatment:

Information obtained from the CP and video footage, showed that on May 15, 2023, the SP and P2 were with a group of children on the toddler playground. The SP walked over and used one hand to pick up the AV by one arm and put the AV on the ground. The CP described the SP's actions as "plopped" the AV down on the ground. The SP walked away and approximately one minute later, the SP walked back over to the AV, raised a ball above the SP's head, and "slammed it with force" on the AV's head. The CP stated it was thrown at the AV's head on purpose.

Although the SP stated s/he threw the ball with one hand at the AV thinking the AV would stop crying and play with the ball and denied that the ball hit the AV on the head, the SP had reason to minimize his/her actions for fear of repercussions. There was no information provided that the CP's account was not credible, and it was supported by the video. The SP's interaction with the AV was inconsistent with the standards of a professional caregiver in a facility licensed by the Department of Human Services; a violation of the facility's policies and procedures; and a violation of Minnesota Rules, part 9503.0055, subpart 3, item A.

Although there was no known injury to the AV, the SP's actions of picking up the AV, who was twenty-five months old, by one arm and throwing a ball at the AV's head and/or hitting him/her on the head represented a substantial risk of injury to the AV. Therefore, there was a preponderance of the evidence that the SP's actions were not accidental, were a failure to supply the AV with necessary care, a failure to protect the AV from conditions or action, and was an overt act that represented threatened injury towards the AV.

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 626.556, subdivision 10e, paragraph (i):

> 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 and supervision of the AV at the time of the incident. The SP was trained on the facility's policies and procedures and the Reporting of Maltreatment of Minors Act prior to the incident.

The SP was responsible for maltreatment of the AV.

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 did not meet statutory criteria to be determined as recurring or serious. The SP's two actions were considered a single incident that met three definitions of maltreatment that did not result in an injury to the AV.

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. The SP no longer worked at the facility.

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

The SP was not disqualified from providing direct care services as a result of the maltreatment determination in this report. However, the SP was notified by the Office of Inspector General that any further substantiated act of maltreatment, whether or not the act meets the criteria for "serious," will automatically meet the criteria for "recurring" and will result in the disqualification of the SP. The determination that the SP was responsible for maltreatment is subject to appeal.

On August 18, 2023, the facility was issued a correctio order for the violation outlined in this report.

Certification:

The information collection procedures followed in this investigation were pursuant to Minnesota Statutes, section 260E.30, subdivision 6, paragraph (c). All individuals that are subjects of data in this investigation have the right to obtain private data on themselves which was collected, created, or maintained by the Department of Human Services.