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: 202305323

Date Issued: August 23, 2023

Name and Address of Facility Investigated:

Early Explorers Child Care & Preschool, Inc.
2935 13th St S
Moorhead, MN 56560

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

License Number and Program Type:

1101408-CCC (Child Care Center)

Investigator(s):

Tessa Ripka
Minnesota Department of Human Services
Office of Inspector General
Licensing Division
PO Box 64242
Saint Paul, Minnesota 55164-0242
tessa.ripka@state.mn.us
651-431-6612

Suspected Maltreatment Reported:

It was reported that a staff person (SP) grabbed an alleged victim's (AV) arm, yanked the AV, and threw the AV on a cot. The AV bit his/her tongue and hit his/her head on the corner of the cot.

Date of Incident(s): June 21, 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 July 6, 2023; from documentation at the facility; and through three interviews conducted with two facility staff persons (SP, P), and the AV's family member (FM).

The AV was four years old at the time of the incident and enrolled in the Into the Jungle preschool classroom.

The *Incident Report Form* and the P provided the following information:

- On June 21, 2023, at approximately 1:30 p.m., the SP relieved another teacher in the classroom during naptime. The teacher in the classroom went on break and told the P that the AV was having a "hard day." The P decided to enlarge the camera footage on the screen in his/her office so that s/he could watch the classroom and assist the SP if needed.

- The P saw the AV get up off his/her cot and the SP placed the AV back on his/her cot. The AV got up again and went and pulled another child's hair. The SP grabbed the AV by one arm, lifted the AV up off the ground, and placed the AV on his/her cot. A third time the AV got up off his/her cot and went to a cabinet in the classroom. The SP redirected the AV to his/her cot. Finally, a fourth time, the AV got up and pulled the same child's hair again. The SP went over and pulled the AV's hair and then picked up the AV and placed him/her forcefully on his/her cot. The AV hit his/her head on the plastic edge of the cot.

- The P grabbed a staff person to cover in the classroom and immediately pulled the SP out of the classroom to discuss the incident. The SP had gotten an ice pack for the AV's head, but the P did not notice any marks or injuries at that time. The P did not feel any bumps on the AV's head.

- The FM later notified the P that the AV was seen by his/her medical provider and that there were nail marks or bruises on one of the AV's arms.

- The P had no previous concerns with the SP besides that s/he had raised his/her voice a "handful" of times.

- In the last few months, that AV had developed some new behavioral issues. The AV hit, pulled hair, and threw things. After an episode it seemed the AV did not remember what had happened. The facility was doing behavioral observations and behavioral logs to try to determine possible patterns. The AV's behavior seemed to escalate when the normal staff person was not in the room and around naptime.

The SP provided the following information:

- The SP went into the classroom to cover a break for another staff person. It was naptime and the children were lying on their cots throughout the classroom.
- The AV refused to stay on his/her cot and the SP redirected the AV to his/her cot "12 to 13" times. At one

point, the SP tried to grab the AV's hand to take him/her back to his/her cot, but the SP did not look down enough and grabbed the AV by his/her wrist.

- The AV got up from his/her cot and walked over to another child and pulled the child's hair. The SP got "a little flustered" and pulled the AV's hair. The SP walked the AV back to his/her cot and put the AV on the cot. The AV hit his/her head on the edge of the cot.

- The AV cried and was upset. A few minutes later the AV told the SP that his/her head hurt, so the SP got an ice pack for the AV. The SP did not notice any injuries to the AV but might have scratched the AV without realizing it. The SP said s/he was sorry and gave the AV a hug before the SP left the classroom.

- The SP only worked with the AV when the SP covered for another staff person. The AV at times chose not to listen and might kick, hit, or spit at staff persons.

Video footage from the date of the incident showed the SP sitting at a table in the classroom while the children laid on cots throughout the room. The AV was on a cot right behind the SP's table. The AV got off his/her cot and ran to another child's cot directly across the room past the SP. The SP came over and grabbed the AV by the left wrist lifting the AV up off the ground while walking the AV back to his/her cot. The SP eventually appeared to grab the AV with the SP's other hand and put the AV down on his/her cot. The SP went and sat back down at the table. As soon as the SP sat down, the AV got up and ran back to the other child's cot and appeared to pull the child's hair. The SP got up and ran to the cot and pulled the AV's hair. The SP then grabbed the AV under both armpits and took him/her back to his/her cot and set the AV roughly onto the cot. It appeared the AV hit his/her head as s/he grabbed toward his/her head after being put down. The SP pulled the AV down lower onto the cot and went and sat back down at the table.

Medical records indicated the AV was seen at the urgent care on June 21, 2023, for arm pain and a headache. No treatment was given by the medical provider, but acetaminophen or ibuprofen was recommended for pain. The AV was to return if there was vomiting, confusion, or focal neurological findings (impairments of nerve, spinal cord, or brain function that affects a specific region of the body).

Photographs provided by the FM showed an approximately 1 inch scratch on the AV's right bicep and four red marks on the underside of the AV's right forearm, closer to the wrist.

The *Policies, Procedures and Program Guide* stated that the following actions were prohibited by or at the direction of the staff persons: rough handling, shoving, hair pulling, ear pulling, shaking, slapping, kicking, biting, pinching, hitting, and spanking.

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 following actions by or at the direction of a staff person: 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:

Video footage and the SP provided consistent information that on June 21, 2023, the SP grabbed the AV by the left wrist, lifting the AV up into the air and put the AV back on his/her cot. Shortly after the AV got up and pulled another child's hair. The SP came over and pulled the AV's hair, picked up the AV, and put the AV down roughly on the AV's cot. The AV bumped his/her head on the plastic edge of the cot. Later it was noticed that the AV had visible marks on his/her right arm.

Although there were points during the incident when it was reasonable for the SP to intervene to prevent the AV from harming others, there was no information that the SP tried any less intrusive means and the SP's actions of pulling the AV's hair, lifting the AV off the ground by his/her wrist while walking the child back to his/her cot, and setting him/her roughly down causing the AV to bump his/her head were not accidental. The AV sustained a raised scratch mark and several bruises/marks on his/her arm which most likely occurred during the incident when the SP picked the AV up off the ground by his/her wrist/arm and were noted later that day when the FM took the AV to get medical care. The SP's actions during the incident were inconsistent with the facility's policies and procedures; and a violation of Minnesota Rules part 9503.0055, subpart 3, item A. Given the aforementioned, there was a preponderance of the evidence that was a failure to provide the AV with necessary care; a failure to protect the AV from conditions or actions that seriously endangered his/her physical or mental health; caused physical injury to the AV; and represented a substantial risk of injury to the AV.

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.)

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 the AV's care and supervision. The SP received training on the facility's policies and procedures and the Reporting of Maltreatment of Minors Act. 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 abuse and neglect for which the SP was responsible was not recurring because it was a single incident but was serious maltreatment because the AV sustained bruises, skin lacerations, and/or 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. All staff persons were reminded of proper redirection and guidance of children. 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 23, 2023, the facility was issued a Correction Order for the violation outlined in this report.

Certification:

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