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: 202304781

Date Issued: September 22, 2023

Name and Address of Facility Investigated:

New Horizon Academy
548 Prairie Center Dr.
Eden Prairie, MN 55344

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

License Number and Program Type:

803892-CCC (Child Care Center)

Investigator(s):

Lindsay Arth/Alice Percy
Minnesota Department of Human Services
Office of Inspector General
Licensing Division
PO Box 64242
Saint Paul, Minnesota 55164-0242
lindsay.arth@dhs.mn.us
651-431-6537

Suspected Maltreatment Reported:

It was reported that an alleged victim (AV) was left unsupervised in the facility's bathroom for 45 minutes. A staff person (SP) was unaware that the AV was not with the SP's group of children on the playground.

Date of Incident(s): May 31, 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 June 23, 2023; from documentation at the facility; and through four interviews conducted with a facility staff person (P1), an administrative staff person (P2), the SP, and the AV's family member (FM).

The AV was three years old and enrolled in the facility's preschool classroom.

The AV's classroom was located next to the toddler classroom. A bathroom area was located between the two classrooms and accessed by each classroom via a half-door. Consistent information was provided that the half-doors were typically kept closed unless a child was using the bathroom. The preschooler children could close the half-door for privacy when using the bathroom, but would be monitored by a staff person while they were in the bathroom. No cleaning supplies were stored in the bathroom. Consistent information was provided that most of the children were able to open the bathroom door from the inside without assistance, but there was no handle on the outside for the children to use to open the door to enter the bathroom.

The bathroom door was located along one wall of the classroom near the outside wall. A sink area was located next to the bathroom. Several tables and small bookcases were placed around the room. A rug was placed on the floor a short distance from the bathroom and that area was used for story time and other group activities.

A video camera was located on the wall opposite the bathroom door and provided a view of much of the classroom, including the door of the bathroom. It provided a limited view of inside the bathroom as children moved around near the two half-doors. The video did not have sound. A review of the video recording for the AV's classroom on May 31, 2023, from 10:00:02 a.m. to 11:08:49 a.m. showed the following:

- At the beginning of the video, several of the children sat on the floor on the rug in the story time area as a staff person (P3) read a story to the children.
- At 10:03:15, P3 stood and put the book away and then walked around the classroom as the children played. P3 walked to the back of the classroom.
- At 10:03:52, the SP walked from the back of the room and talked to the children while looking at an iPad. The SP continued to interact with the children as s/he walked around the classroom.
- At 10:11:08, the SP entered the bathroom and was followed by a child. The SP then stood outside the bathroom door while the child used the bathroom. Other children used the bathroom as the SP continued to stand outside the bathroom door and as P3 walked around the classroom.
- At 10:14:25, P3 walked to the back of the classroom and then left the classroom. The SP remained by the classroom door as the children took turns entering the bathroom.
- At 10:17:38, the AV entered the bathroom as the SP stood outside the door.
- At 10:17:47, the SP closed the bathroom door and walked to the sink area as the other children walked around the classroom.
- At 10:21:34, the AV moving around the bathroom.
- At 10:34:12, the SP took a child's hand and the SP and the children moved out of range of the video camera.
- At 10:34:32, the AV moved around the bathroom as a staff person walked past the bathroom door in the toddler classroom.
- At 10:34:49, the last child moved out of the camera range as the group, including the SP, left the classroom. The AV continued to move around the bathroom.
- At 11:03:08, P1 walked by the bathroom door in the toddler classroom.

- At 11:03:18, P1 opened the door and bent down next to the AV.
- At 11:03:27, P1 took the AV out of the bathroom through the toddler classroom door.

P1, P2, the SP, and the facility's documentation provided the following information:

- On May 31, 2023, the SP worked in the preschool classroom with nine children. That morning, three of the children "did not listen and were running around hitting children." In preparation for taking all of the children to the playground, the SP had them use the bathroom. The SP stated that when all of the children were out of the bathroom, s/he shut the door, but was unaware that the AV was still in the bathroom. The SP applied sunscreen to the children and at approximately 10:30 a.m., the SP took the group of children outside to the playground.

- The SP stated that s/he typically counted the children before they went outside, when they arrived at the playground, and then again when they returned to the classroom. The SP did not recall making a "mistake" when counting the children, but did not know if the AV was included when s/he counted the children during the transition from the classroom to the playground.

- P1 stated that his/her group of children were also on the playground when the SP's group of children were on the playground. At some point, P1 entered the facility before the other staff persons supervising his/her group of children in order to set up the cots for nap time after the children returned to the facility and had lunch. As P1 walked past the bathroom, s/he saw the AV's hand waving over the top of the closed bathroom door. When P1 opened the bathroom door, the AV stood there with his/her pants pulled down and told P1 that s/he "needed help." The AV was not upset, but appeared to be "confused." The AV did not have any injury. P1 helped the AV with pulling up his/her pants and then took the AV outside to join the SP's group of children.

- P1 did not tell the SP that s/he found the AV unsupervised in the bathroom because s/he did not want the SP to ask P1 not to tell anyone about the incident. Later that day, P1 told P2 about the incident. P2 watched the video and determined that the AV was unsupervised in the bathroom for approximately 15 minutes while the SP was with the other children in the classroom. Once the SP and the other children left the classroom with the other children, it was approximately 30 minutes until P1 found the AV in the bathroom.

- The SP stated that s/he did not know that the AV was left unsupervised in the bathroom until P2 asked the SP about it the next day the SP worked at the facility. P2 asked P1 why s/he did not tell the SP that the AV was found unsupervised in the bathroom and P1 told P2 that s/he "didn't think it was my place."

- The SP stated that s/he used white boards to track how many children were in his/her classroom. All of the children's names were written on the white board and the SP used the white board when counting the children. P1 stated that the staff persons also used iPads to keep a current list of the children in their classrooms. P2 stated that the SP should have used a rope when transitioning the children from the classroom to the playground, but was uncertain if the SP did so on the day of the incident. The SP stated that s/he did not get a rope for the children to hold on to during transitions until after the incident.

The FM stated that P2 told him/her about the incident. The FM did not believe the AV had any distress over the incident and was still attending the facility. The FM had no concerns about the care the AV received at the facility.

According to the facility's *Risk Reduction Plan*, when transitioning children from one area to another, the staff

persons were to have the children form a line using a walking rope. The staff person was to call the children by name as they hold onto the rope, using name to face counting every time the walking rope was used. If only one staff was present, they were to walk at the front of the line facing the children. The staff persons were to count the children to ensure that all children were present.

According to the facility's *Welcome to Day One* training, the staff persons were trained to "never leave the children unattended for any reason." All children were to be within sight and sound at all times.

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

Relevant Rules and 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.

Conclusion:

A. Maltreatment:

On May 31, 2023, the SP worked in the preschool classroom with nine children. At 10:17 a.m., the AV entered the bathroom and the SP closed the bathroom door. At 10:34 a.m., the SP and the other children left the classroom and went to the playground as the AV remained in the bathroom. At 11:03 a.m., P1 walked past the bathroom while s/he was in the adjoining toddler classroom and saw the AV in the bathroom. P1 assisted the AV with pulling up his/her pants and then took him/her to join the other children on the playground. The AV was unsupervised for 45 minutes which was a violation of Minnesota Statutes, section 245A.02, subdivision 18 and Minnesota Rules, part 9503.0045, subpart 1, item A.

The SP was not aware that the AV was left unsupervised in the bathroom and was not on the playground with the SP and the rest of the children until P2 told the SP about the incident on a subsequent day. The AV, who was three years old, was unsupervised for approximately 45 minutes in the facility's bathroom, which exposed the AV to dangers and staff persons inability to intervene in the event of an emergency. Therefore, there was a preponderance of the evidence that there was a failure to supply the AV with necessary care and a failure to protect the AV from conditions or actions that seriously endangered the AV's 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 and/or 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.

Facility documentation showed that the SP received training on the Reporting of Maltreatment of Minors Act and on the facility's policies 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 for which the SP was responsible did not meet statutory criteria to be determined as recurring or serious because it was a single incident and the AV did not sustain an injury that required the care of a physician.

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 the facility's policies were adequate, but not followed by the SP. 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 September 22, 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.