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: 202305232

Date Issued: October 20, 2023

Name and Address of Facility Investigated:

Lake Area Discovery Center at Our Savior's Lutheran Church
1616 West Olive Street
Stillwater, MN 55082

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

License Number and Program Type:

1029801-CCC (Child Care Center)

Investigator(s):

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Suspected Maltreatment Reported:

It was reported that a staff person (SP) picked up an alleged victim (AV) while the AV was having behaviors, which resulted in the AV sustaining bruises on his/her arms and fingerprint marks on his/her torso.

Date of Incident(s): June 14, 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 29, 2023; from documentation at the facility, video footage, and photographs and video taken by a family member (FM1) of the AV's; and through five interviews conducted with two supervisory staff persons (P1 and P2), two facility staff persons (P3 and the SP), and FM1.

According to the AV's enrollment information, the AV was 35 months old at the time of the incident and enrolled in the "young threes" (older toddler) room at the time of the incident.

The facility was located inside a church and the older toddler room had a door that led to a hallway. Near the end of the hallway was an external glass door. The external door opened to a sidewalk that went the length of the building to a parking lot and then trees.

Consistent information was provided that the SP generally worked at another childcare center operated by the same license holder but occasionally subbed at the facility. In the morning of July 14, 2023, P2 and P4 worked in the older toddler room and the SP and P3 worked in the afternoon. The day prior, P4 and the SP worked in the room.

FM1 provided the following information:

- On June 14, 2023, at approximately 3:30 p.m., a family member (FM2) of the AV picked the AV up at the facility. FM2 came home and told FM1 that the AV was in the younger toddler room when FM2 arrived at the facility. FM2 went to the older toddler room and spoke to the SP, who was "still agitated." The SP said that earlier in the day, the AV did not listen about picking up a toy. The SP gave the AV to the count of three and the AV "started throwing a fit." The AV cried so the SP picked the AV up and "held" him/her. During that time, the AV "went limp" and hit his/her head on concrete. The SP told FM2 that the SP was "not supposed to be in that room" (subbing). The SP did not provide FM2 with an incident report.

- The AV had a "normal" evening at home. At approximately 7:30 p.m., FM1 changed the AV into pajamas and saw four lines on the AV's right shoulder blade that resembled marks from fingers and also fingerprints. FM1 lifted both of the AV's arms and saw that "all under" the AV's armpits were red with bruising developing. FM1 took photos and a video of the injuries. FM1 said that the marks had broken capillaries and went away after four days.

- FM1 called P1 and told him/her about the injuries. P1 said s/he would talk to the SP and follow up. Later, P1 called FM1 back and said that the SP told P1 that earlier that day, the AV had not been listening about picking up a toy so the SP "restrained" the AV because the AV was "self-harming" and putting other persons in danger.

- That night at bedtime, FM1 asked the AV if s/he got an "owie" at the facility. The AV was "on the verge of sleep" and shook his/her head, "No."

- The following day, FM1 and FM2 received an incident report that the SP completed. The incident report did not include any information about the AV hitting his/her head on concrete and had more to do with the AV's behavior instead of the injuries. The incident report also said that the AV's behavior was the cause of the AV being picked up under his/her armpits. The incident report also included information about going outside and the AV "throw[ing him/herself] on the ground" which the SP had not told FM2

the day prior. FM1 and FM2 asked P1 for a meeting, and P2 became involved.

- On June 16, 2023, FM1, FM2, and P2 met at the facility for approximately two hours. P2 presented the meeting as ways to work on the AV's behavior. FM1 and FM2 expressed their unhappiness with the first incident report so P2 agreed that the SP would write another incident report. FM1 and FM2 asked multiple times in the conversation about how the AV sustained the marks on his/her body and P2 would not provide the information.

- The AV did not have a history of bruising when persons picked the AV up. The AV attended the facility since s/he was an infant and the usual staff persons knew the AV well and s/he "never" had a behavior report prior to this.

Photos and video provided by FM1 showed the AV had red marks in both of his/her underarms. There were approximately three small, circular bruises on the AV's right shoulder blade/torso with lighter red marks toward the AV's armpit.

P2 provided the following information:

- On the morning of June 14, 2023, P2 subbed in the older toddler room. During that time, the AV "refuse[d]" to assist in cleaning up toys. P2 gave the AV verbal reminders to assist the other children in cleaning up. When the other children moved on to the next activity, P2 kept the AV in the same area and reminded the AV that once s/he picked up toys, s/he would be allowed to join the rest of the children but the AV refused. The AV then tried walking over by the other children and P2 reminded the AV to clean up the toys but the AV lay on the floor and "flailed." P2 told the AV it appeared that the AV's body needed calming so P2 picked up the AV under his/her arms and carried the AV to the calm area inside the room.

- The AV eventually went and cleaned up the toys and then joined the rest of the children and the SP at the next activity (circle time). The AV needed verbally reminders as s/he continued to "struggle" with sitting in one spot and "pushed boundaries" until it was snack time. Historically while in the older toddler room, the AV had a history of "passive noncompliance" and "a lot of behaviors" including sitting on the floor and refusing to move.

- P2 also had a child in the older toddler room and later that day at pick up, the SP told P2 that it had been a "hard day" with all the children in the room and probably would not come back to sub in that room again. P2 did not recall if the SP specifically mentioned the AV during that conversation.

- On June 15, 2023, P2 again subbed in the older toddler room. The AV had "some behaviors" that P2 "intervened with" including helping the AV find an alternative place inside room until s/he was able to listen. While assisting the AV with moving to the quiet place, P2 placed his/her hands under the AV's armpits to carry the AV to a calmer area.

- Later on that day, P2 and other supervisory staff persons received an email with an incident report about the allegations completed by the SP. Either that evening or the following morning, P2 contacted FM1 and FM2 to schedule a meeting to discuss the incident. P2 felt s/he did not need to look into the incident further based on the information already provided to him/her so P2 did not reach out to P3.

P3 provided the following information:

- P3 worked with the AV since s/he was approximately 16 months old. The AV was "very sweet" but also got "upset" especially during clean up time. In the past, P3 walked over to the AV and verbally reminded the AV to pick up toys. If the AV refused, then P3 picked up the toy with the AV and walked it over to where it belonged. In other instances, P3 asked another staff person for assistance with the AV.

- On the day of the incident, P3 was asked to stay late and assist the SP in the older toddler room. When P3 went into the room, the SP was telling the children that they were going to go outside but needed to clean up first. The SP sat on the floor with the AV on the SP's lap trying to get the AV to pick up a toy. The AV refused and the SP "insist[ed]" that the AV do it and then it turned into a "struggle" between the SP and the AV. The SP appeared "lost" and was "not happy" with the AV not picking up the toy and the AV was "not happy" that the SP insisted on the AV picking up the toy. P3 "never" had a child including the AV be so reluctant to do what they were told.

- P3 walked over to the SP and suggested that in the past, P3 put the toy in the child's hand and helped the child walk to where it belonged. The SP was "frustrated" and said something along the lines of "I know that" to P3. The SP stood up and helped the AV bring the toy to the shelf. During that time, the AV kicked and "thr[ew] a fit." P3 could "sense [the SP's] anger" and was "a little bit" concerned with the SP's interactions with the AV.

- The SP then told the children including the AV it was time to go outside and walked them to the hallway door. At that point, the AV did not want to go outside and P3 told the SP so. The SP walked over to the AV who was crying and "angry" and the SP "insisted" that the AV was going outside on a walk to the playground.

- The SP brought the AV to the front of the line of approximately 12 children as P3 was at the back of the line. The SP held the AV while walking the children down the hallway and outside. P3 suggested that the SP allow the AV to walk but the AV refused.

- The SP held the AV under his/her arms and it was a "struggle" between the SP and the AV. The AV screamed, kicked, and cried as the SP tried holding onto the AV. P3 was concentrating on the other children but also was "very aware" of the SP and the AV's interactions.

- There was a physical struggle between the SP and the AV of the AV wanting to get away from the SP and the SP wanting the AV to come on the walk. There was "a lot" of the SP trying to hold onto the AV and the AV trying to "fight" the SP. There was a lot of "anger" coming from the SP and s/he was "so insistent" that the AV come on the walk and behave. The AV wanted down and at one point, the SP set the AV down on the ground and wanted the AV to walk but the AV refused to walk and wanted to go back inside the facility.

- The SP should have been "calmer" in talking and letting the AV know s/he cared about him/her and wanted the AV to enjoy the walk. P3 did not see "compassion" from the SP for the AV, only "frustration and anger." The interactions should not have happened between a staff person and child.

- The SP, P3, and the children continued walking and P3 could not imagine the AV walking near the parking lot. P3 told the SP s/he did not think the AV should go with P3, the SP, and the other children and that the AV should go back inside. The SP agreed and brought the AV back inside while P3 stayed with the

other children.

- Approximately five minutes later, the SP came back outside and they continued their walk without the AV. P3 stated s/he was "very disturb[ed]" because s/he had "never seen" anything like that between a staff person and child prior to the incident. The SP was "angry" during the incident.

- Several days after the incident, P3 heard from an unknown staff person that the AV had bruises from the struggle between the SP and the AV and it "did not surprise" P3 because of the SP's and the AV's interactions.

Video footage in the hallway outside the older toddler room provided by the facility, an incident report completed by the SP on June 15, 2023, and the SP provided the following information:

- The SP stated that on the day prior to the incident (June 13, 2023), the SP subbed in the room for approximately one and a half hours. The AV displayed "behaviors" including not wanting to walk so another staff person (P4) carried the AV outside to the playground while the SP assisted the other children. The AV was "upset" when on the playground and the SP gave the AV a few verbal redirections, but the AV did not respond.

- In the afternoon of June 14, 2023, the SP subbed for approximately two hours in the room with P3 and approximately 13 children, including the AV. When the SP arrived, the children were playing with toys. The SP gave the children a five-minute warning to clean up toys prior to going outside. Some of the children began to clean up toys and line up at the door to go outside.

- The SP stated that the AV continued playing with a toy so the SP went over and reminded the AV it was time to clean up the toy. The AV had a basket on his/her head, took it off, threw it, and yelled, "No." The AV then tried to run away from the SP, but the SP caught up and told the AV it was time to put the toys away. The AV "threw" him/herself onto the floor and "scream[ed]" so the SP asked the AV if s/he wanted the SP to assist the AV with putting the toy away. The AV refused so the SP told the AV that s/he was going to count to three to allow the AV to put the toy away otherwise the SP would assist the AV with putting it away. The SP counted to three and the AV was still "not calm" so the SP held the AV's hand and picked up the toy. The AV "immediately pulled away" from the SP and lay on the floor. The SP got on the floor as well and told the AV s/he was going to pick him/her up. The AV continued to kick and flail but the SP was able to pick up the AV.

- The SP picked the AV up and carried the AV and the toy to the shelf. The AV was placed on the floor to stand while the SP put the toy on the shelf. The SP then told the AV that they were "all done" and were able to go on the walk. The AV again dropped to the floor, kicked, and cried. The SP picked up the AV and carried him/her to the door to prepare for the walk.

- The video footage showed that on June 14, 2023, at 1:50 p.m., the SP and the AV stood inside the room at the baby gate and the AV cried. The SP placed his/her hands on the AV's upper arms and turned the AV back to face inside the room. The SP's back was to the camera and blocking the AV but the AV was visible when s/he dropped onto the floor. The SP assisted the AV with standing but the SP's hands were not visible. The SP then picked up the AV and carried the AV on the SP's hip.

- The other children were lined up at the baby gate. The SP used his/her right hand to open the baby gate

while his/her left hand held the AV. The SP then used both of his/her hands to set the AV down. During that time, the AV lifted his/her feet and legs. The SP set the AV down and the AV laid down on his/her back in front of the gate while still inside the room.

- The SP opened the gate and walked through it with eleven other children following out into the hallway. The SP got a walking rope while P3 and the twelfth child stood behind the AV. P3 used his/her hands on the AV's upper arms and torso to lift the AV and the AV dropped back onto the floor. P3 tried another time to lift the AV under his/her armpits. During that time, the AV's feet were off the floor and kicking. P3 walked a couple of steps and set the AV back onto the floor. The AV crawled out of the view of the camera and P3 and the twelfth child stepped out into the hallway.

- P4 carried the AV from out of the camera view and handed the AV to the SP who was at the front of the line of children. While handing the AV, the AV's feet dangled in the air and the SP tried standing the AV on the floor. The AV dropped to the floor while the SP held the AV's upper arms.

- The SP kneeled onto the floor, turned the AV to face the SP, and spoke to the AV. During that time, the SP held the AV by the AV's upper arms or armpits while P3 assisted the other children. The AV continued to lift his/her feet in the air during the interaction.

- The SP then stood up, turned the AV around, held the AV's upper arms while the AV's feet kicked in the air. The SP was at the front of the line with the AV, twelve children behind them along the walking rope, and P3 at the back of the line. The SP continued to hold onto the AV under his/her armpits while the AV kicked. The AV's feet were off the floor the whole time and at one point, the AV dropped to the floor. The AV's shoe came off his/her foot and the SP used one of his/her hands to pick up the shoe and put it back on the AV's foot while the SP's right hand continued holding the AV under his/her right armpit. The SP and the AV then continued walking.

- Video footage showed at 1:54 p.m., the SP and the AV reached the door to outside. The SP used his/her right hand to hold the AV's left hand while the AV stood and the SP used his/her left hand to open the door. The other children and P3 followed. (Note: The facility did not provide video footage of outside or once the SP returned inside with the AV. This investigator asked for the additional footage and the facility said they did not have any additional footage of the incident.)

- The SP stated after walking through the door and outside, P3 suggested to the SP that they should have left the AV inside. The SP agreed and told P3 to wait outside with the other children and the SP carried the AV back inside to the younger toddler room. The SP used his/her right arm under the AV's torso to carry the AV and the left other hand, held the AV's legs so s/he was not able to kick the SP. The AV's head was near the SP's elbow and the SP described it as how to hold a sleeping baby with the AV's stomach facing the floor.

- The incident report completed by the SP stated that once they returned inside, the AV stayed in the younger toddler room with a staff person and those children. Once inside with the younger toddlers, the AV showed signs of calming and the SP went back outside. Once the SP and the older toddlers returned inside, the AV was "happy" and stayed with the younger toddlers the remainder of the day.

- During the incident, the SP either picked up the AV under the AV's armpits and carried him/her or stood

behind the AV holding the AV under his/her armpits and guiding the AV to walk. The SP denied putting his/her hands on the AV's torso area. The SP denied that the AV hit his/her head on the cement. The SP told FM2 at pick up that the AV used his/her body to drop and that s/he rolled his/her head on the cement side to side when kicking but denied saying that the AV fell and hit his/her head. The SP denied being frustrated during the incident and stated s/he was able to manage the other children and sing songs with the children. Later on, the SP said that "in the end" the SP was frustrated s/he was not able to assist the AV with changing to allow the AV to do things on his/her own.

P1 provided the following information:

- On the day of the incident, at approximately 6 p.m., FM1 and FM2 contacted P1 by phone and explained that the AV had bruises under his/her armpit that resembled a handprint. They sent a picture of the marks to P1, and P1 did not see a handprint mark but did see redness under the AV's armpit. P1 told FM1 and FM2 that s/he would follow up with the SP.

- P1 then called and spoke to the SP who said earlier that day, s/he was helping the AV with cleaning up and getting ready for a walk. The AV did not want to do either of those things and was "screaming" and "throwing toys." The SP offered to help the AV with walking and the AV refused so the SP held the AV under his/her armpits and helped the AV walk. The AV "collapsed" into the SP's hands "with all [his/her] weight" during that time so the SP set the AV down on the floor.

- On June 15, 2023, the SP filled out and completed the incident report that was given to FM1. Later on, P1 and other supervisory staff persons received an email from FM1 requesting a meeting because of the inconsistent information in the incident report and what was told to FM1 and FM2. There was an email discussion on who should meet with them. During that email conversation, the SP mentioned that when the AV "collapsed" on the floor, s/he hit his/her head on his/her fist. P1 was not aware that the AV hit his/her head on concrete. The AV had a history of being "stubborn" and P1 had not worked with the AV since s/he was in the infant room.

According to the facility's *Behavior Guidance Plan*:

- The facility promoted a positive approach to managing the behavior of all children, including the following:
    - A well-designed environment that prevented "frustration, interruptions, and hazards." The facility maintained "stimulating" rooms so the children engaged in productive and positive activities.
    - Staff persons used positive redirection involving redirecting "unacceptable behavior" to an "acceptable alternative." Staff persons recognized children for their appropriate behavior and successful interactions.
    - Staff persons taught and modeled appropriate behavior that helped children "pattern positive responses." When needed, staff persons demonstrated such things as "gentle touches."
    - Staff persons used "clear and simple" rules such as "walking feet, inside voices, listening ears, and gentle touches" to help children achieve acceptable standards.
    - Staff persons appealed to the child's "growing intellectual and moral reasoning" through use of natural and logical consequences. Staff persons regularly reminded children to "use their words" to resolve issues.
- Children were in the process of learning appropriate behavior. They were constantly experimenting with

different actions and looking for direction and limits. The facility's method included recognition and encouragement of appropriate behavior as often as possible.

- When inappropriate behavior was apparent, the *Five Step Behavior Guidance Plan* was carried out in order for staff persons to "insure the safety of all the children" and staff persons.
    - Staff persons stood near, looked at, and placed his/her hand on the child's shoulder to show a child that his/her behavior was not acceptable.
    - Staff persons led the child to a new activity to avoid conflict, possibly separating from a toy.
    - Staff persons assisted the child to solve the problem, think of alternate solutions, modeled words to use instead of physical reaction, allowed the child to "voice [his/her] feelings," and acknowledged other persons feelings.
    - Staff persons asked the child to assist in "remedying the situation" such as after a child knocked over another child's blocks on purpose, s/he was asked to assist in picking the blocks up. All consequences for unacceptable behavior were "immediate" and related to the inappropriate behavior.
    - Children were not separated from the group unless the previous steps were taken and ineffective or the child's behavior threatened the well-being of the child or children in the group.

- If a child consistently showed unacceptable behavior, the following steps were taken:
    - The persistent, unacceptable behavior was observed/recorded by staff persons along with written documentation on how staff persons responded to the behavior and that documentation was kept in the child's file.
    - Staff persons informed a supervisory staff person of the inappropriate behavior, their observations, documentation, and response to the behavior. The supervisory staff person provided feedback and offered suggestions on ways to handle the behavior.
    - If staff persons or supervisory staff persons felt the behavior was "not diminishing" after implementing the *Behavior Guidance Plan*, the child's family members were notified and it was documented.
    - A meeting was scheduled with the family members, staff persons, and a supervisory staff person. If needed, additional support persons were consulted. If all avenues were exhausted and staff persons felt the child would have been better at another facility, staff persons assisted family members with finding a new facility.

- The facility promoted the rights of children served and strived to protect their health and safety during an "emergency use of physical hold" which was defined as a physical hold when a child posed "an imminent risk of physical harm to [his/herself] or others" and was the least restrictive intervention that achieved safety. Property damage, verbal aggression, or a child's refusal to receive or participate programming on his/her own did not constitute an emergency. The following was used to de-escalate a child's behavior before it posed an imminent risk of physical harm to his/herself or others:
    - Staff persons followed the *Five Step Behavior Guidance Plan*.
    - Other examples included: reinforcing appropriate behavior; offering choices to the child, including activities that were relaxing and enjoyable; using positive verbal guidance and feedback; actively listening to the child and validating his/her feelings; speaking calmly with reassuring words, considering volume, tone, and nonverbal communication; and simplifying a task or routine, or discontinuing until the child was calm.

- Physical contact or instructional techniques "must" have been the least restrictive alternative as possible

to meet the needs of the child. The following was allowed on an "emergency basis" when a child's conduct posed an imminent risk of physical harm to him/herself or others and least restrictive strategies did not achieve safety:

- Physical intervention or contact used as a behavior management technique to guide or carry the child to safety or away from an unsafe or potentially harmful and escalating situation.
- One staff person arm restraint in standing or seated position.

- A *Behavior Update Report Form* was completed after the use of a physical hold and included the name of the staff person and child involved in the incident, and included the positive/alternative measures from the *Behavior Guidance Plan* that were attempted to de-escalate the incident and maintain safety and identify the alternative measures attempted prior to the physical hold. This report was shared with and signed by family members and placed in the child's file and a supervisory staff person was notified.

Facility documentation showed that all staff persons, including the SP, received training on the *Behavior Guidance Plan* and the Reporting of Maltreatment of Minor's Act prior to the incident.

Relevant Rules and Statutes:

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

Minnesota Rules, part 9503.0055, subpart 4, stated that no child may be separated from the group unless the license holder tried less intrusive methods of guiding the child's behavior which have been ineffective and the child's behavior threatens the well-being of the child or other children in the center. A child who requires separation from the group must remain within an unenclosed part of the classroom where the child can be continuously seen and heard by a program staff person. When separation from the group is used as a behavior guidance technique, the child's return to the group must be contingent on the child's stopping or bringing under control the behavior that precipitated the separation, and the child must be returned to the group as soon as the behavior that precipitated the separation abates or stops.

Conclusion:

A. Maltreatment:

On June 14, 2023, at approximately 7:30 p.m., FM1 changed the AV into pajamas and saw four lines on the AV's right shoulder blade that resembled marks from fingers and also fingerprints. FM1 lifted both of the AV's arms and saw that "all under" the AV's armpits were red with bruising developing. FM1 took photos and a video of the injuries, which were consistent with his/her description.

The facility provided partial video footage of the incident that showed on multiple occasions, the SP carried the AV under his/her arms and armpits in the room and in the hallway walking outside with the other children and P3, During the interactions, the AV dropped to the floor or took his/her weight off his/her legs so all of the AV's weight was on the SP's hands. Toward the end of the SP's interactions with the AV, s/he carried the AV to another room where s/he stayed until pick up time, which was a violation of Minnesota Rules, part 9503.0055, subpart 4.

P3 had concerns with the SP's and the AV's interactions and said that the SP was frustrated and angry with the AV. Given that the AV was not a danger to him/herself or others there was no reason for the SP to physically intervene. In addition, there was no information that prior to the SP intervening the AV's behaviors were aggressive. Therefore, the SP physically intervening with the AV in a manner that caused bruising, which was a violation of Minnesota Rules, part 9503.0055, subpart 3, item A, and there was a preponderance of the that the SP's interactions toward the AV were not accidental and were a failure to supply the AV with reasonable and necessary care and a failure to protect the AV from conditions or actions that seriously endangered his/her physical or mental health.

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.

The SP was trained on the *Behavior Guidance Plan* and the Reporting of Maltreatment of Minor's 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 for which the SP was responsible did not meet statutory criteria to be determined as recurring or serious because it was a single incident for which the AV did not sustain a serious injury that reasonably 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 policies and procedures were adequate and followed. Staff persons received additional training on completing incident reports and behavior management of a child. Additional training was also given on providing information to family members.

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 October 20, 2023, the facility was issued a Correction Order for the violations outlined in this report.
In addition, it was determined that facility mandated reporters had knowledge of the alleged incident and did not

report the incident as required. The license holders were each ordered to forfeit a fine of $200 for failure to report maltreatment. The Order to Forfeit a Fine is 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.