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: 202304968

Date Issued: October 31, 2023

Name and Address of Facility Investigated:

Little Rascals Learning Center, Inc.
1924 North Franklin
New Ulm, MN 56073

Disposition: Maltreatment determined as to neglect of the alleged victim by two staff persons.

License Number and Program Type:

1056006-CCC (Child Care Center)

Investigator(s):

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Suspected Maltreatment Reported:

It was reported that an alleged victim (AV) was left unsupervised in a public park. The staff persons were not aware that the AV was missing until a community person (CP1) told them that a child was left at the park.

Date of Incident(s): June 8, 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 21, 2023; from documentation at the facility, and law enforcement records; and through eight interviews conducted with a supervisory staff person (P4), facility staff persons (P1, P2, P3, SP1, and SP2), the AV's family member (FM), and a community person (CP2).

The facility was located in a commercial area on the corner of a four-lane divided highway with a speed limit of 50 miles per hour and a two-lane street. The facility shared a large parking lot with four other commercial businesses. Two of the businesses were located next to the facility on the divided highway. Directly across the parking lot from the facility was the Brown County license bureau, which was on the corner of two, two-lane streets. Across a two-lane street from the license bureau was a public park (North Park). Along the two-lane street from the facility to North Park was a sidewalk.

North Park was used by the facility as the playground and was a large open area approximately one block from the facility. In order to reach the park from the facility, it was necessary to cross the parking lot and then a two-lane street. Two-lane streets ran along all four sides of the park. A residential area was located across the street from one side of the park and there were several businesses across the street from the park on the remaining three sides. There were no fences around the park. The upper portion of the park contained two pavilions with barbeque grills, swings, two large climbing structures, a zip line, a merry go round, a splash pad, and benches. A ladder to a platform at the top of one climbing structures was seven- and one-half feet high. (This was the ladder the AV fell from.) The upper playground was used by the facility preschool children. A grassy area under some of the trees extended down a small hill to the rest of the park with playground equipment that was lower to the ground. This lower playground area was used by the facility toddler children.

The AV was two years and seven months old and enrolled in the facility's toddler classroom at the time of the incident.

A facility *Incident Report Form* showed that on June 8, 2023, at approximately 4:30 p.m., the toddler staff persons took thirteen toddlers from the lower park to the upper park and then walked back to the facility on a sidewalk. As they group walked back, staff persons counted the children and some children were picked up by family members. When the group arrived back at the facility, staff persons completed another count and realized a child was missing. At the same time, a telephone call from a community person was received stating that a child had been left at the park. A staff person went to North Park, got the AV and brought him/her back to the facility unharmed. The AV's family member was told of the incident when s/he picked up the AV that evening.

The FM stated that his/her friends had seen posts on a local social media site regarding the incident and sent a screen shot of the post to the FM. The FM was aware the AV had been left at the park before the facility told another family member about the incident at the end of the day when that family member picked up the AV from the facility. The FM was also told that the AV had fallen off a ladder on the play equipment. The FM stated the AV seemed fine. Prior to this incident the FM did not have concerns about the facility and the AV still attended the facility.

Law enforcement documentation and CP2 provided the following information:

- On June 8, 2023, at 4:52 p.m., a law enforcement officer (LEO) took a telephone call from a community person (CP1) that stated s/he had been at North Park at approximately 4:10 p.m., when a group of children left the park and headed back toward the facility. CP2 stated that at approximately 4:40 p.m. a

child (later determined to be the AV) climbed up the ladder to the playground structure platform, fell, and started to cry. CP2 asked other community persons at the park if the AV was with them but they said s/he was not. Another community person suggested that the AV may have been from a childcare center that had just been at the park.

- CP2 googled childcare centers and found a facility that was 600 feet away and called the facility. The facility did not "confirm or deny" that they had lost the AV but said they would send a staff person to the park. A staff person then came to the park and took the AV back to the facility. CP1 and CP2 estimated the AV was unsupervised at the park for approximately 30 to 35 minutes.

- The LEO went to the facility and talked with P3. P3 told the LEO that SP1 and SP2 had been with the toddler children at the park. They played at the lower park and walked to the upper park and then walked back to the facility. P4 arrived at the facility and briefly talked with the LEO. The LEO then called and spoke with one of the AV's family members, who stated the AV was "alright."

- On June 9, 2023, P4 called the LEO and told him/her that s/he had statements from staff persons and that SP2 was at the facility and wanted to talk with the LEO. The LEO went to the facility and talked with SP2. SP2 told the LEO that as they walked from the lower park to the upper park, s/he was at the end of the line and the AV was directly in front of him/her. Once at the upper park, they joined the preschool group and walked back to the facility. During this time no head count was completed. When they arrived back at the facility at approximately 4:30 p.m., SP2 was changing diapers in the toddler room, when another staff person came into the room and asked if anyone had seen the AV. Prior to that, SP2 had not realized the AV was missing.

- Then the LEO talked with SP1 by telephone. SP1 provided information that was consistent with the information SP2 provided. SP1 did not know when or how the AV left the group.

- The law enforcement report was forwarded to the city attorney, who declined to press charges.

P1, P2, P3, P4, SP1, and SP2 and written statements from P1, P3, P4, and SP1 each gave to the LEO provided the following information:

- On June 8, 2023, P2 and SP1 were on the upper playground at North Park with a group of preschool children and P1 and SP2 were on the lower playground with a group of toddler children. At approximately 4:15 p.m., the toddlers sat at a table drinking water when SP1 went from the upper playground to the lower playground to relieve P1. P1 gave SP1 a notebook that contained the names and the number of children and told SP1 that it was time for them to walk up the hill, join the preschool group to walk back to the facility. P1 could not recall the exact number of children but thought at that time there were 13 or 14 toddlers present. P1 then left the park, walked back to the facility, and worked in the infant classroom.

- When SP1 arrived at the lower playground, s/he saw that there were 13 children on the notebook page and counted the children on the playground, completing a name to face check of the children, including the AV. SP1 and SP2 then walked the children to the upper playground. SP1 stated s/he held the AV's hand as they walked to the upper playground but SP2 stated the AV was in front of him/her as they walked up the hill. At the top of the hill SP1, SP2, and the toddler children joined the preschool class on the sidewalk. P2 stated that the toddler group of children were directly behind the preschool line of

children. SP1 was at the front and SP2 was at the back of the toddler line. P2 did not hear either SP1 or SP2 count the toddlers before they left the upper playground. SP1 stated s/he did not count again because s/he was "overwhelmed" by the two groups of children. SP2 stated that s/he did not complete a count of the children when the group left the park or while the group walked back to the facility.

- As both groups walked back to the facility, some of the toddlers mixed with the preschool children, some children tried to go to the road and SP1 got them back in line, and three toddlers left with family members because it was the end of the day. The walk back to the facility took between ten and fifteen minutes. When they arrived at the facility parking lot, P2 helped a student with a wagon that carried supplies and did not enter the facility with the preschoolers or toddlers so P2 did not know if another count of the children was completed when the children walked through the facility entrance door. SP1 also helped with the wagon so s/he did not complete a count when the group arrived at the facility. SP2 stated that s/he did not count the number of children when they returned from the park or before they entered facility.

- Once back at the facility P3 and SP2 were in the toddler classroom. SP2 was changing diapers when SP1 entered the classroom after assisting with the wagon. SP1 crossed off the names of the three children who had left and then conducted a name to face check. At that time, SP1 "assumed" that the children who s/he did not see were in the bathroom with SP2. Then SP1 left the toddler classroom to take out trash and was out of the toddler classroom for approximately 5 minutes.

- At approximately 4:30 p.m., P1 answered a telephone call and talked with a community person (later determined to be CP2). CP2 asked P1 if a child from the facility had been left at the park. P1 immediately left the infant classroom, walked into the toddler classroom, and asked if they had left a child at the park. P3 immediately left the facility, walked to the park, and saw the AV being held by CP1. CP1 told P3 that the AV had fallen off the play equipment. P3 thanked CP1 and took the AV from him/her and walked back to the facility. P3 took the AV into an infant classroom, looked the AV over and saw a scratch on the AV's elbow. P3 then gave the AV water to drink. Then P3 telephoned P4 and the AV's family member and let each know that the AV had been left at North Park.

- P4 was not at the facility at the time of the incident but at approximately 5:40 p.m., s/he received a telephone call from P3, who said the AV had been left at the park. P4 then drove to the facility and talked with the law enforcement officer and P1, P2, SP1, and SP2. P4 stated that staff persons were trained to count children when they left the facility, once they were on the public sidewalk, and upon arrival at North Park. When leaving the park, staff persons lined the children up, conducted a name to face attendance and counted, checked the park one more time, and then walked back to the facility. Staff persons were also trained to count children when they returned to the facility. The group would form a line along the facility wall and staff persons would count the number of children present.

According to the facility's *Employee Handbook*, each child was to be supervised at all times and no child was to be left unsupervised. While on the playground, staff persons were to spread out around the area so that all areas were supervised. In the morning, as children arrived, a staff person in the room wrote down each child's name in a notebook so there was an updated student list to use for name to face recognition. When a group walked to the park, once at the park a staff person counted and used the class list in the notebook and completed a name to face check. While at the park, staff persons communicated the number of students present with other staff persons. The handbook did not provide information regarding when staff persons returned from the park.

According to the facility's *Risk Reduction Plan*, when at the park's playground, staff persons circled the park and kept a count of the children. Staff persons were not to leave children unsupervised and were to count the children when going to and from any area and when exiting and entering the facility.

Facility documentation showed that the P1, P2, P3, P4, SP1, and SP2 were each trained on the facility's policies and on the Reporting of Maltreatment of Minors Act prior to the incident.

Relevant Rules and/or Statutes:

Minnesota Statutes, section 245A.02, subdivision 18, and Minnesota Rules, part 9503.0045, subpart 1, item A, state that a child must have supervision at all times and that supervision is defined as occurring when 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.

Conclusion:

A. Maltreatment:

Information from all sources was consistent that on June 8, 2023, SP1 and SP2 were at the lower level of North Park with a group of toddler children. When it was time to return to the facility, SP1 and SP2 lined up the children, including the AV, and walked up the hill to the upper playground. The toddler group joined the preschool group at the upper park and as a large group they walked back to the facility, and the AV was left at the upper portion of North Park unsupervised which was a violation of Minnesota Statutes, section 245A.02, subdivision 18, and Minnesota rules, part 9503.0045, subpart 1, item A. Once SP1 and SP2 were back at the facility and in the classroom, they engaged in other classroom duties and did not realize the AV was missing until CP2 telephoned the facility to inquire if they had left a child at the park. P3 walked to the park and found the AV being held by a community person. The AV was unsupervised for approximately 30 minutes.

Being unsupervised on the unfenced park playground gave the AV access to dangers including falling, exposure to unknown community persons, parking lots, businesses, and streets. In addition, when the AV was unsupervised at the park s/he fell from the play structure ladder and no staff person was there to intervene. Therefore, there was a preponderance of the evidence that there was a failure to supply the AV with the 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 SP1 and SP2 received training on the Reporting of Maltreatment of Minors Act and on the facility's policies including the supervision policy and transitioning to and from the park prior to the incident.

At the time of the incident, SP1 and SP2 were responsible for the supervision of the children at the park, including the AV. SP1 and SP2 were each 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 SP1 and SP2 were responsible did not meet statutory criteria to be determined as recurring or serious because it was a single incident of maltreatment for which the AV did not sustain an injury that required the care of a physician.

However, information obtained by the Department of Human Services, in combination with this report, would result in SP1 being disqualified for recurring maltreatment.

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.

<u>Action Taken by Facility</u>:

The facility completed an internal review and determined their policies and procedures were inadequate. The facility rewrote polices to include face to name recognition and verbal communication of the number of children between staff persons. Staff person were retrained on the new policies.

<u>Action Taken by Department of Human Services, Office of Inspector General</u>:

SP1 was notified that s/he was responsible for recurring maltreatment and that any future background studies for facilities, 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, will result in his/her disqualification. The determination that SP1 was responsible for maltreatment is subject to appeal.

SP2 was not disqualified from providing direct care services as a result of the maltreatment determination in this report. However, SP2 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 disqualification. The determination SP2 was responsible for maltreatment is subject to appeal.

On October 31, 2023, the facility was issued a Correction Order for the violation outlined in this report.

On October 31, 2023, the facility was issued a Order to Forfeit a Fine of $200 for a background study violation.

<u>Certification</u>:

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.