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: 202306541

Date Issued: November 22, 2023

Name and Address of Facility Investigated:

Warm World Child Development Center
13575 58th Street North
Oak Park Heights, MN 55082

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

License Number and Program Type:

805063-CCC (Child Care Center)

Investigator(s):

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Suspected Maltreatment Reported:

It was reported that an alleged victim (AV) fell off a diaper changing countertop when a staff person walked away from the table. The AV sustained a fractured arm.

Date of Incident(s): July 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 August 9, 2023; from documentation at the facility and medical records; and through three interviews conducted with a facility supervisory staff person (P), a facility staff person (SP), and the AV's family member (FM).

According to the AV's enrollment information the AV was thirteen months old and enrolled in the facility's "Butterfly" infant classroom at the time of the incident.

The "Butterfly" infant classroom was an open space and along one wall was a countertop that was divided into two sections. One section was for diaper changes and had a handwashing sink. The countertop was approximately three feet off the floor. Across from the countertop was a large table with built in seats for infants. Near the table was an adult wooden rocking chair. The facility had video cameras in the classroom that provided live feed and recorded footage.

The FM provided the following information:

- On July 31, 2023, when s/he picked up the AV, s/he signed an accident report that the AV had fallen down while standing and hit his/her lip on the table. The FM was not concerned at that time, but later that night notice that when the AV lay on the floor and rolled, s/he got "stuck" because s/he would not use his/her left arm.

- At the facility the next morning, the FM asked an unknown staff person if s/he had seen the AV fall the day before. That staff person told the FM that s/he did not see the AV fall because s/he was not in the room, but s/he would talk with the SP when s/he saw him/her. The FM then left the AV and went to work.

- Approximately two hours later, the FM received a telephone call from the P asking the FM to come to the facility because the P and the SP wanted to talk with him/her. The FM left work immediately and when s/he arrived at the facility, the P told the FM that the AV had fallen off the countertop (diaper changing area) the previous day. The P had the SP come into the facility office and explain to the FM what had happened. The SP told the FM that the AV was on the countertop and fell off and that it was the SP's fault that the AV fell. The SP told the FM that s/he was "scared," so because the AV did not bleed, the SP did not write an incident report or tell the FM when s/he picked up the AV that evening. Then that morning, the SP noticed the AV was not using his/her arm and told the P about what happened the day before.

- The FM then took the AV to a local medical facility where s/he was referred to an orthopedic facility. At the orthopedic facility, the AV was diagnosed with two fractures in his/her left arm.

The AV's medical records showed that on August 1, 2023, the AV was seen at a local medical facility for arm pain. The AV's left humerus and forearm was x-rayed which showed "a buckle fracture of the radius and ulna metaphysis." The AV's arm was placed in a "short-arm" cast and needed repeat x-rays one week later. On August 8, 2023, the AV was seen and was doing well with the cast and the fracture was healing.

A facility *Incident/Accident/Injury report* showed that on July 31, 2023, at 9:50 a.m., the AV was walking when

s/he tripped and hit his/her left cheek to his/her nose on a metal bar on the table. The SP treated the AV with an ice pack and "TLC." The report was not signed by a supervisor but was signed by the FM on July 31, 2023, at 4:45 p.m.

Video footage dated July 31, 2023, was from one camera located in the Butterfly classroom and showed most of the classroom, including the diaper changing area. The video footage provided the following information:

- On July 31, 2023, at 9:38 a.m., the SP sat in the rocking chair while four children, including the AV, played on the floor. After approximately 42 seconds the SP stood up and walked across the room. The AV followed the SP and two other children walked to the rocking chair. The SP picked up the AV, walked to the countertop diaper changing area, placed changing paper on the counter surface, and lay the AV on the countertop. The SP put on gloves and took out wipes while two children leaned on the seat of the rocking chair. The SP looked to his/her left and then looked at the children at the rocking chair. The SP then left the AV on the countertop and walked approximately six feet to the rocking chair. With his/her back to the AV, the SP moved one child from the rocking chair. (The SP picked up the child roughly by one arm which was a violation of Minnesota Rule 9503.0055, subpart 3, which states that the license holder must have and enforce a policy that prohibits subjection of a child to corporal punishment which includes, but was not limited to, rough handling, shoving, hair pulling, ear pulling, shaking, slapping, kicking, biting, pinching, hitting, and spanking.)

- As the SP moved the second child from the rocking chair, the AV, who was still on the countertop diaper changing area, rolled to his/her right and fell to the floor. The SP immediately turned around, walked to the AV, picked him/her up, and placed him/her back on the countertop. (At this point it does not appear that the SP asses the AV for any injury.) Then the SP raised the AV's legs, lowered the AV's pants to his/her ankles, wiped the AV, picked up the AV's head between both of his/her hands, and moved the AV's head from side to side while looking at it. Then the SP lay the AV's head back on the countertop, put a diaper on the AV and pulled up the AV's pants. The SP picked the AV up and held him/her around the stomach, facing away from the SP. Then the SP looked at and touched the AV's head and placed the AV on the SP's hip. The SP walked near the rocking chair and placed the AV on his/her bottom on the floor as the AV cried. The SP walked to another child and picked up him/her and walked back to the diaper changing countertop and placed the child on the countertop. The SP then changed that child's diaper. (The SP did not wash the AV's hands or his/her hands and did not change the paper or sanitize the diaper changing counter between use. This was a violation of the facility's health policies and *Diapering Procedure* and a violation of Minnesota Rules 9503.0140, subpart 3 and subpart 4, which stated that a child's hands and a staff person's hands must be washed with soap and water after a diaper change and Minnesota Rule 9503.0140, subpart 12, which stated that a facility must develop diaper changing procedures in consultation with a health consultant and must be followed by staff persons.)

- While the SP changed the child's diaper, the AV stood up and then stumbled approximately six steps backward and fell forward on his/her stomach. The AV pushed him/herself to standing position using both arms and walked a few steps and cried. The AV put both hands to his/her face and head and walked to a soft mat and lay down. The AV then sat up on the soft mat and fell forward on his/her stomach. The SP took the child off the countertop and placed him/her on the floor without washing the child's hands or his/her own hands. (This was a violation of Minnesota Rules 9503.0140, subpart 3 and subpart 4, and Minnesota Rule 9503.0140, subpart 12.) Then the AV stood up and the SP walked to the AV and picked up him/her and the video ended.
- A second video segment from July 31, 2023, at 3:28 p.m., showed three children, including the AV, seated

in bucket chairs at the table eating a snack as the SP walked toward the classroom door with a mop in one hand and a bucket in the other. The SP opened the classroom door, stepped out of the classroom, and the door shut. (The SP was out of the classroom for 15 seconds which left the children unsupervised. which was a violation of Minnesota Statute 245A.02, subpart 18, and Minnesota Rules 9503.0045, subpart 1, item A, which stated that a child must have supervision at all times and that supervision was defined as occurring when a program staff person was within sight and hearing of a child at all times so that the program staff can intervene to protect the health and safety of the child.) When the SP returned to the classroom, s/he removed a child from the chair and placed him/her on the floor without washing the child's hands.

The P provided the following information:

- On August 1, 2023, the P was in his/her office and received a telephone call from the SP, who was in the Butterfly classroom. The SP told the P that s/he wanted to talk with him/her about something so the P sent another staff person to cover the Butterfly classroom and the SP went to the office. The SP told the P that the AV fell off the countertop diaper changing area the previous day, when the SP "looked away." The SP did not tell anyone at that time but now the AV was not putting weight on his/her arm.

- The P then called the FM and asked him/her to come to the facility. While the P waited for the FM to arrive at the facility, the P reviewed video footage from the incident and saw that the SP walked away from the AV who was on the countertop diaper changing area and did not look away as the SP told the P, and the AV fell. The P again spoke to the SP about what the P had seen on video and the SP started to cry. The live feed from the video camera was on the monitor in the P's office on July 31, 2023, but the P did not see the AV fall from the countertop because s/he was not looking at the monitor. The SP also told the P that earlier in the day, the AV fell and hit the table, but the P could not confirm that with video footage because the power had gone out and the video camera did not record during that time period.

- When the FM arrived at the facility, the SP told him/her that the previous day, as s/he changed the AV's diaper, the AV fell off the countertop diaper changing area. The P asked the FM to take the AV to a doctor and so the FM and the AV left the facility.

- On August 2, 2023, (the next day) the P received a telephone call from the FM. The FM told the P that the AV's arm was broken and casted. The FM sent a photo of the cast to the P.

The SP provided the following information:

- On July 31, 2023, at approximately 9 a.m., the AV fell and hit his/her face on the table in the classroom sustaining a mark on his/her nose and cheek. The SP held an ice pack on the marks and made sure the AV was okay. The SP wrote an *Incident/Accident/Injury* report for this fall.

- Later that morning, at approximately 9:45 a.m., the SP had placed the AV on the countertop diaper changing area when s/he saw children "messing" with the rocking chair. The SP "stepped back" approximately "six inches" from AV and told the two children to stop messing with the chair. The SP did not want them to bang the chair against the wall or get hurt by climbing on and falling off of the rocking chair. As s/he did this, out of the corner of his/her eye, the SP saw the AV fall off the countertop diaper changing area and land on the floor on his/her left side.
- The SP walked to the AV, picked him/her up, and looked him/her over to be sure s/he was not bleeding

and did not see any bumps or bruises. The SP said s/he then "cuddled" the AV to make sure s/he was "okay." The AV cried for less than a minute. The SP then changed the AV's diaper and looked him/her over again. The AV looked "fine" and they "went on with their day." The AV ate lunch and snack and took a nap. The SP did not provide first aid to the AV because the AV "seemed okay." The SP did not write an *Incident/Accident/Injury* report because s/he "panicked" and was "scared."

- Later that day, when the FM picked up the AV, the SP gave the FM the *Incident/Accident/Injury* report for the first incident and told the FM the AV fell and hit his/her face on the table leg. The FM signed the report and left the facility with the AV. The SP did not tell the FM that the AV fell from the countertop diaper changing area.

- The next day, after the AV arrived in the classroom, the SP noticed the AV was not using his/her left arm and when the AV tried to stand up it was different from how s/he had done so previously, so the SP decided to tell the P what had happened the day before. From the classroom, the SP telephoned the P who was in his/her office and then the SP went to the office and told the P that the AV had fallen off the countertop diaper changing area the day before.

- The P called the FM who came to the facility. The SP then told the FM that the AV fell from the countertop diaper changing area the previous day and that the SP had not been truthful. The SP stated the FM was "understanding" and told the SP that s/he also had a hard time changing the AV's diaper too because the AV rolled around. The SP went back to the Butterfly classroom and continued to work.

- The next day, August 2, 2023, the P told the SP that the AV sustained a fractured arm. The SP did not think the AV would have received medical attention sooner had s/he initially told the FM the truth, because the AV appeared to be "fine" after the fall.

- The SP stated s/he knew s/he should keep one hand on a child when s/he changed their diaper because s/he had been trained on the policy and because s/he had worked with infants for a long time.

The facility's posted *Diapering Procedure* showed that when preparing to change a diaper, a staff person's first step was to wash their hands with warm running water and soap for 20 seconds. The staff person then gathered supplies, covered the diapering surface with paper, and put on gloves. During the "dirty" phase a staff person placed a child on the countertop diaper changing area and kept a hand on the child at all times when changing the child's diaper. During the "clean" phase, the child's and staff person's hands were washed thoroughly with warm running water and soap for 20 seconds. During the "clean up" phase, the staff person cleaned and disinfected the diaper surface, and all surfaces touched, and then again washed his/her hands thoroughly with warm running water and soap for 20 seconds. During the "communicate" phase, the staff person reported any and all concerns to parents.

The facility's *Risk Reduction Plan* showed that staff persons kept at least one hand on a child when the child's diaper was changed. It also showed that staff persons properly handled children and provided adequate supervision of children.

Facility documentation showed that the P and the SP were trained on the facility's health policies, including the *Diapering Procedure*, and *Risk Reduction Plan,* and the Reporting of Maltreatment of Minors Act prior to the incident.
Relevant Minnesota Rules and/or Statutes:

Minnesota Statutes, section 245A.66, subdivision 2, paragraph (d), clause (9), states that a facility must develop a risk reduction plan that include development and implementation of specific policies and procedures or refer to existing policies and procedures that minimize the risk or harm or injury to a child, including children falling from changing tables.

Conclusion:

A. Maltreatment:

Information showed that on July 31, 2023, at approximately 9:38 a.m., the SP placed the AV on the countertop diaper changing area. Then the SP left the AV on the countertop diaper changing area and walked approximately six feet away from the AV, which was a violation of the facility's *Risk Reduction Plan* and *Diapering Procedure*, and violations of Minnesota Statutes, section 245A.66, subdivision 2, paragraph (d), clause (9); and Minnesota Rule 9503.0140, subpart 12. The AV rolled and fell off the countertop and fell approximately three feet to the floor sustaining two fractures in his/her left arm. While the SP stated s/he provided comfort to the AV by "cuddling" him/her immediately after the fall, the video contradicted this and showed that the SP placed the AV on the countertop and continued to change his/her diaper. The SP did not notify the P or the FM of the fall until the next morning when s/he saw that the AV would not use his/her left arm.

The FM stated that after picking the AV up from the facility on July 31, 2023, s/he noticed that the AV would not use his/her left arm and the next morning asked an unknown staff person about it, who stated they were not in the room and that they would ask the SP about it.

Given the AV's age and that the SP walked away from the AV after placing the AV on the countertop diaper changing area, which was three feet high, the AV was at risk for a fall and in fact, fell off onto the floor, sustaining two fractures in his/her arm. In addition, the SP failed to notify the facility or the FM of the AV's fall which caused a delay in medical care and increased the amount of time the AV experienced pain. Therefore, there was a preponderance of evidence that there was a failure to provide 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 failure to protect a child from conditions or actions that seriously endanger a 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 responsible for the care and supervision of the AV at the time of the incident and was trained on the facility's *Diapering Procedure* and *Risk Reduction Plan,* 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 neglect for which the SP was responsible did not meet the statutory criteria to be determined as recurring because it was a single incident. However, the incident was serious because the AV sustained two fractures in his/her left arm that required the care of a physician.

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 their policies and procedures 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 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 November 22, 2023, the facility was issued a Correction Order for the violations outlined in this report, failing to wash children's hands before eating, and a staff person not seated with children during snack time.

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.