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: 202308813

Date Issued: February 14, 2024

Name and Address of Facility Investigated:

Creekside Montessori
106 East Diamond Lake Road
Minneapolis, MN 55419

Disposition: Maltreatment determined as to neglect of an alleged victim by a staff person. A non-maltreatment mistake to the alleged victim by two other staff persons was not maltreatment.

License Number and Program Type:

801496-CCC (Child Care Center)

Investigator(s):

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Suspected Maltreatment Reported:

It was reported that an alleged victim (AV) was left in a bathroom without three staff persons' (SP1, SP2, and SP3) knowledge or supervision for approximately twenty-four minutes.

Date of Incident(s): October 13, 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 October 27, 2023; from documentation at the facility; and through seven interviews conducted with the AV, the AV's family member (FM), and facility staff persons (P1, P2, SP1, SP2, and SP3).

The facility was located in a multi-level church. The facility used the main level and the lower level of the church. On the main level were facility classrooms, including Children's House 4 (children 33 months to six years). On the lower level, accessible by an open staircase, was a vestibule. Off the vestibule was a dining room used by the facility for large muscle play, a hallway with other rooms used by church, and two adult bathrooms that were used by the facility. The adult bathroom the AV used had two sets of wood doors that were held open with door stops. Inside the bathroom were two stalls, two hand sinks, a small stool, and a trash can.

Facility documentation showed the AV was four- and one-half years old and enrolled in the Children's House 4 preschool classroom at the time of the incident.

The AV stated that when the SP brought him/her to the bathroom, s/he "got stuck" in the bathroom when the SP did not come back. The bathroom door was "too heavy," and the AV could not open the door. The AV walked around the bathroom and "missed" his/her family members until another staff person found him/her.

The FM stated that on Friday, October 13, 2023, SP3 notified him/her that the AV was left in the bathroom when staff persons failed to check the bathroom before transitioning from the basement to the classroom. The AV was found by a facility staff person (later identified as P2). Later in the day, the FM talked with the AV about the incident and the AV retold the same story. The AV was not afraid to attend the facility since the incident. Prior to this incident, the FM did not have concerns regarding the facility, and the AV still attended the facility.

The facility provided video footage of the incident that was 25 minutes and 13 seconds long. The video showed a portion of the vestibule in the basement of the church. The video was date and time stamped but did not have audio. The video footage provided the following information:

- On October 13, 2023, at 11:20:52 a.m., the AV appeared at the bottom right corner of the video. The AV talked with someone out of camera view and then walked out of view.
- At 11:24:11 a.m., SP2 walked into camera view with a cart and then walked out of view.
- At 11:24:28 a.m., SP3 led a group of children to the staircase and waited for a few seconds and then SP1 walked into view with a few more children. SP3, SP1, and the children walked up the stairs.
- At 11:44:06 a.m., P2 walked through the vestibule and then reappeared with the AV. Then P2 and the AV walked up the stairs.

P1, P2, and a facility *Injury/Incident Report* provided the following consistent information:

- On October 13, 2023, at approximately 11 a.m., the children from Children's House 4, SP1, SP2, and SP3 were in the basement in another room and transitioned into the room used for large muscle activities. Then SP3 left the area and took a break. SP1 and SP2 were substitute staff persons in Children's House 4.

- At approximately 11:25 a.m., SP1 escorted the AV to the bathroom in the basement and then returned to the large muscle room. While the AV was in the bathroom, the interior door jamb moved and caused that door to shut. The AV was unable to open the door and return to the group.
- When SP3 returned from his/her break, the group transitioned back to their classroom in the main level.

At approximately 11:40 a.m., P2 walked into the basement bathroom and found the AV near the door crying. P2 hugged the AV and asked the AV his/her name. The AV did not tell P2 his/her name and replied, "Children's House 4." P2 took the AV upstairs and into his/her classroom and gave the AV to SP3. SP3 took the AV by the hand but did not say anything to P2. P2 did not speak to SP1 or SP2 when s/he left the AV with SP3. P2 then left the classroom and returned to his/her classroom. P2 waited until his/her break later that afternoon to tell P1 about the incident.

- Attendance was tracked either on a clipboard with children's names and whether that child is checked in or tracked on an iPad. Staff persons were trained to count when leaving an area for another space to ensure all children were accounted for.

SP1, SP2, and SP3 provided the following consistent information:

- On October 31, 2023, SP1 was "subbing" in Children's House 4 for the first time and did not know the children. SP1 was not given a list of children or told how many children were present in Children's House 4. SP1 "roughly" guessed there were 20 children in the classroom that day but did not complete an accurate count because she was not in a teacher role that day and had been trained to count. SP1, SP2, SP3, and the children transitioned to the basement of the church for a music program and at that time, SP1 attempted to count the children but the line was "very long" and children rounded a corner. At approximately 10:30 a.m., the group left the music program and went to the large muscle room in the basement. The children were "amped up" from the music program and some of the children wrestled. SP1 was concerned about the safety of the children present and looked for SP3 but did not see him/her. SP1 asked SP2 if s/he knew how long the group would be in the large muscle room. SP2 told SP1 that SP3 had gone on break, and they would go back to their room when SP3 came back. SP3 did not tell SP1 that s/he was going on break.

- At some point, the AV told SP1 that s/he needed to use the bathroom. SP1 did not tell SP2 s/he was leaving the room and walked the AV to the bathroom. The outer door to the bathroom was propped open and the interior door was shut. SP1 opened the inner door and watched the AV go into a stall and then shut the door for privacy. SP1 thought the AV was five years of age because of his/her height and thought s/he could use the bathroom without supervision. SP1 left the AV and went back to the large muscle room to help SP2. SP1 did not think the interior door was so heavy the AV could not open it.

- SP1 said s/he did not check on the AV in the bathroom because s/he saw another child who resembled the AV and thought the AV had rejoined the group.

- SP1 stated that when SP3 returned from break, the group stayed in the large muscle room a "little longer." When SP3 determined it was time to go back to the classroom, s/he rang a bell and lined the children up against a wall by the door of the large muscle room. Then, SP3 lead the children out and up the stairs. SP1 was at the end of the line. SP3 did not count the number of children before leaving the basement.

- SP2 stated that s/he thought there were 17 children present on October 31, 2023. SP2 stated that s/he

did not see SP1 take the AV to the bathroom. When it was time to go back to the classroom, SP2 left the large muscle room with a cart that held supplies. SP2 walked to the elevator and rode the elevator up a floor. SP2 did not walk up the stairs with the group.

- SP3 stated that after s/he returned to the large muscle room from his/her break, s/he looked to the bathrooms and did not see either SP1 or SP2 standing outside the bathrooms supervising any children inside the bathrooms and s/he "assumed" all the children were present. S/he told the children that it was time to line up. The group lined up in the large muscle room and then SP3 led the group out and to the stairs. SP3 was at the front and SP1 was at the end of the line. Then the group walked up the stairs and to their classroom. SP3 stated s/he did not count the number of children present before the group left the vestibule area and walked up the stairs. SP3 stated that "sometimes" when leaving the basement s/he does not count because "there is no way out." SP3 stated that s/he "should have counted" before the group left the basement. SP3 did not communicate the number of children present to either SP1 or SP2 before leaving on break and before leaving the basement.

- When the group arrived at Children's House 4, SP2 opened the classroom door and SP1, SP3, and the children walked into the classroom. SP2 did not recall if SP3 counted the number of children as the group went into the room. SP2 stated that SP3 typically counted children when they left the playground or the basement because s/he was the leader, and the leader was the "counter." SP2 did not count the number of children present.

- SP3 stated that approximately ten minutes after the group returned to the classroom, P2 brought the AV into the room. (Note: Video showed it was approximately 24 minutes later.) The AV was crying. P2 told SP1, SP2, and SP3 that s/he had found the AV in the basement bathroom. SP3 took the AV and comforted him/her with a hug and asked the AV what had happened. The AV told SP1 that s/he thought someone had locked him/her in the bathroom because s/he could not open the door. P2 told SP3 that s/he had found the AV in the bathroom. SP3 thanked P2 and P2 left the classroom. Shortly after the AV was brought to the classroom, s/he was picked up and left the facility. Later that afternoon, SP3 discussed the incident with P1. P1 and SP3 concluded the AV had been unsupervised approximately 20 minutes. SP3 notified the FM and told him/her about the incident.

- SP1 stated the AV was exposed to hazards in the bathroom while unsupervised that included slipping, falling, and pinching his/her fingers while attempting to open the door.

The facility's *Risk Reduction Plan* showed children are supervised at all times. When groups transitioned from one area to another within the facility, staff persons counted the number of children to ensure that all children were present. The Risk Reduction Plan also showed that when children used a bathroom, a staff person provided supervision from the doorway of the bathroom.

Facility documentation showed that P1, P2, SP1, SP2, and SP3 each received training on the Reporting of Maltreatment of Minors Act and on the facility's policies, including the *Risk Reduction Plan*, 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.

Minnesota Statutes, section 245A.02, subdivision 18, paragraph (c), states that when a single preschooler uses an individual, private restroom within the classroom with the door closed, supervision occurs when a program staff person has knowledge of the child's activity and location, and can hear the child, and checks on the child at least every five minutes.

Conclusion:

Consistent information was provided that on October 13, 2023, the AV was left in the basement adult bathroom for approximately 24 minutes without the knowledge or supervision of staff persons which was inconsistent with the standards of a professional caregiver in a facility licensed by the Department of Human Services; a violation of the facility's policies and procedures; and a violation of Minnesota Statutes, section 245A.02, subdivision 18, and Minnesota Rules, part 9503.0045, subpart 1, item A.

Neither SP1, SP2, nor SP3 counted the number of children before leaving the basement or entering the upstairs classroom and SP1, SP2, nor SP3 knew that the AV was missing from the group and was unsupervised.

Minnesota Statues 260E.30, subdivision 3, paragraph (b), clause (1-5) states that a "non-maltreatment mistake" occurs when:

(1) At the time of the incident, the individual was performing duties identified in the center's child care program plan required under Minnesota Rules, part 9503.0045;
(2) The individual has not been determined responsible for a similar incident that resulted in a finding of maltreatment for at least seven years;
(3) The individual has not been determined to have committed a similar non-maltreatment mistake under this paragraph for at least four years;
(4) Any injury to a child resulting from the incident, if treated, is treated only with remedies that are available over the counter, whether ordered by a medical professional or not; and
(5) Except for the period when the incident occurred, the facility and the individual providing services were both in compliance with all licensing requirements relevant to the incident.

Regarding SP2 and SP3:

Although the AV was unsupervised for approximately 24 minutes without staff person's knowledge and found and returned to the classroom by P2, SP2's and SP3's actions and conduct including not counting the children were determined to be a non-maltreatment mistake for the following reasons:

(1) At the time of the incident, SP2 and SP3 were performing job related duties, as required by the facility's policies; and neither SP2 nor SP3 were aware that SP1 brought the AV to the bathroom and left the AV unsupervised in the bathroom.
(2) SP2 and SP3 had not been determined responsible for a previous incident that resulted in a finding of maltreatment for the last seven years;
(3) SP2 and SP3 had not been determined to have committed a non-maltreatment mistake under this paragraph for at least four years;
(4) There were no injuries to the AV as a result of this incident; and

(5) Except for the period when the incident occurred, the facility, SP2, and SP3 were in compliance with all licensing requirements relevant to the incident.

Regarding SP1:

A. Maltreatment:

SP1 brought the AV to the bathroom without informing SP2 or SP3. SP1 stated that s/he left the AV unsupervised in the bathroom because s/he thought that based on the AV's height the AV was five years old and allowed to be unsupervised in the bathroom. However, and according to Minnesota Statutes, section 245A.02, subdivision 18, paragraph (c), when a single preschooler uses an individual, private restroom within the classroom with the door closed, supervision occurs when a program staff person has knowledge of the child's activity and location, and can hear the child, and checks on the child at least every five minutes. The bathroom was a public church bathroom, at no point did SP1 check on the AV, and it was unlikely that staff persons could hear the AV from the large muscle area. Therefore, this was a violation of Minnesota Statutes, section 245A.02, subdivision 18, paragraph (c).

Although the AV was in the facility basement and returned to the classroom unharmed, leaving the AV unsupervised was not accidental and exposed the AV to dangers inside the bathroom. In addition, given that staff persons were not aware the AV was it the bathroom, they would not have been able 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 could seriously endanger the AV's physical 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.

SP1, SP2, and SP3 received training on the facility's policies and procedures, including the facility's *Risk Reduction Plan* and the Reporting of Maltreatment of Minors Act.

At the time of the incident, SP1, SP2, and SP3 were working in Children's House 4 and responsible for the care and supervision of all the children in the classroom, including the AV. SP2 and SP3 did not count the children during transition however, given that SP3 was on break and not with the group when SP1 took the AV to the bathroom and that SP2 was unaware that SP1 took the AV to the bathroom and did not walk with the group from the basement to the classroom and took the elevator with supplies, SP2's and SP3's conduct met the requirements for a non-maltreatment mistake. SP2 and SP3 were not responsible for the maltreatment of the AV.

SP1 was the sole staff person who took the AV to the bathroom, left the AV in the bathroom, and did not ensure the AV returned to the group. SP1's actions resulted in the AV being unsupervised in the bathroom for approximately 24 minutes. Therefore, SP1's action did not meet the requirements for a non-maltreatment mistake, and SP1 was responsible for the 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 was responsible did not meet statutory criteria to be determined as recurring or serious as it was a single incident and the AV was not injured and did not require 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 their policies were adequate but not followed. SP1 no longer worked at the facility.

Action Taken by Department of Human Services, Office of Inspector General:

SP1 was not disqualified from providing direct care services as a result of the maltreatment determination in this report. However, SP1 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 that SP1 was responsible for maltreatment is subject to appeal.

SP2 and SP3 were not determined as perpetrators of maltreatment of the AV because the Department of Human Services found that the incident for which SP2 and SP3 were responsible met the criteria to be determined a nonmaltreatment mistake. SP2 and SP3 were each notified by the Office of Inspector General that any future incident of possible neglect of an alleged victim for which SP2 and/or SP3 is responsible might not be considered a non-maltreatment mistake.

On February 14, 2024, the facility was issued a Correction Order for the violations 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.