

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: 202400889

Date Issued: March 8, 2024

Name and Address of Facility Investigated:

Kinderberry Hill Child Care Development Center, II
3950 W 70th St
Edina, MN 55435

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

License Number and Program Type:

801288-CCC (Child Care Center)

Investigator(s):

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Suspected Maltreatment Reported:

It was reported that an alleged victim (AV) was left unsupervised on the playground for approximately 12-14 minutes.

Date of Incident(s): January 30, 2024

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 February 7, 2024; from documentation at the facility; and through four interviews conducted with three facility staff persons (SP1, SP2, P), and the AV's family member (FM). Due to the AV's age, s/he was unable to provide any information about the incident.

The AV was 33 months old at the time of the incident and enrolled in the Intermediate B classroom.

SP1 and SP2 provided the following information to this investigator and through written statements:

- On January 30, 2024, SP1 and SP2 were in the Intermediate B classroom with 14 children. This was not the normal classroom for SP1 or SP2. SP1 and SP2 took the children out to the playground at approximately 9:30-9:45 a.m.
- When it was time to come inside, SP1 and SP2 called the children to line up against the wall of the facility. SP1 did a head count of the children twice and counted 14 on each occasion. SP2 led the children inside while SP1 was at the back of the line carrying one child who required more care. In the hallway a parent arrived to pick up a child.
- The class arrived back to the classroom at approximately 10:23 a.m. Both SP1 and SP2 said they did not count the children upon returning to the classroom. SP2 assisted some children in the bathroom while SP1 assisted the children with removing their outside clothing when s/he noticed the AV was not in the classroom.
- SP1 asked SP2 if the AV was in the bathroom. SP2 said, "No," and so SP1 checked the hallway and finally the playground where SP1 found the AV under a climbing structure. The AV did not appear distressed and was not crying. SP1 brought the AV back to the classroom at approximately 10:40 a.m. and notified his/her supervisor.
- SP1 expressed concerns that s/he did not have education or experience to be in the preschool classrooms and had education specific to infants and toddlers. SP1 also expressed concerns about never having worked with the AV or the other child that needed more support.
- SP2 expressed concerns about the chaos of the day and that s/he had never been a lead staff person in that classroom before. SP2 said that the children were "allowed to run wild with no structure" in the classroom. The attendance sheet was confusing and there were names on the chairs in the classroom which were incorrect.

The P provided the following information:

- On the day of the incident, SP1 told the P that the AV had been left in the playground. The AV did not seem "fazed" and was happy the rest of the day.
- Typically during transitions children were lined up with one staff person in the front and one staff person in the back. The staff persons counted the children as they came in the door and counted them again in the classroom.

- The P had no previous concerns with SP1 or SP2.

The FM had no previous concerns with the facility.

Video footage showed that on January 30, 2024, at 11:18 a.m., the children appeared to gather by the wall (out of camera view). SP1 walked toward the facility following several children. The AV played in the far-left corner of the playground. Other children walked past the camera at 11:19 a.m. (likely going inside). From 11:20 a.m. to 11:39, the AV played on the playground, climbing on the play structures, kicking a ball, and wandering around the playground. At 11:22 a.m., the classroom entered the classroom. The children came in and started taking their winter clothing off. SP1 and SP2 came in last and shut the door. SP1 assisted the children with taking off winter clothing while SP2 gathered some boots and put them away. At 11:27 a.m., SP2 went into the bathroom and assisted some children using the bathroom. SP1 continued to assist other children with their winter clothing. At 11:38 a.m., SP1 grabbed a pair of shoes and looked at the children, s/he appeared to talk with SP1 who also looked around. SP1 then went out the classroom door. At 11:39 a.m., SP1 returned to the classroom with the AV.

According to www.wunderground.com, the outdoor condition at the facility, on January 30, 2024, at the time of the incident, was “cloudy” with a temperature of 39 degrees Fahrenheit (°F) and wind speed of 12 miles per hour (mph).

The *Employee Handbook* stated that staff persons never left the children unattended for any reason and accurately counted the children at each transition. Children were within sight and sound at all times.

The supervision policy stated that attendance was taken during major transitions including going outdoors, coming indoors, and leaving one area and arriving at another.

Facility documentation showed that SP1 and SP2 were trained on the facilities policies including the *Employee Handbook* and the Reporting of Maltreatment of Minors Act.

Relevant Rule and/or Statute

Minnesota Statutes, section 245A.02, subdivision 18, and Minnesota Rules, part 9503.0045, subpart 1, item A, states 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 was consistent that on January 30, 2024, the AV was left on the facility’s playground without the knowledge or supervision of a staff person for approximately nineteen minutes, which was a violation of Minnesota Statutes, section 245A.02, subdivision 18, and Minnesota Rules, part 9503.0045, subpart 1, item A. SP1 and SP2 were each not aware that the AV was still on the playground when they took the other children back to the classroom, which was inconsistent with the standards of a professional caregiver in a facility licensed by the Department of Human Services and a violation of the facility’s policies and procedures.

Although the playground was fenced, the AV, who was 33 months old, was unsupervised for nineteen minutes with no staff person available to intervene if the AV attempted to do something dangerous, injured him/herself, or in the event of an emergency. In addition, neither SP1 nor SP2 counted the children when they returned to the classroom from the playground. Therefore, there was a preponderance of the evidence that there was a failure to supply the AV with necessary care and a failure to protect the AV from conditions or actions that seriously endangered the AV's physical or mental health when reasonably able to do so.

It was determined that neglect occurred (failure by a person responsible for a child's care to supply a child with necessary food, clothing, shelter, health, medical, or other care required for the child's physical or mental health when reasonably able to do so and/or failure to protect a child from conditions or actions that seriously endanger the child's physical or mental health when reasonably able to do so).

B. Responsibility pursuant to Minnesota Statutes, section 260E.30, subdivision 4, paragraph (a), clauses (1) and (2):

When determining whether the facility or individual is the responsible party, or whether both the facility and the individual are responsible for determined maltreatment in a facility, the investigating agency shall consider at least the following mitigating factors:

- (1) whether the actions of the facility or the individual caregivers were according to, and followed the terms of, an erroneous physician order, prescription, individual care plan, or directive; however, this is not a mitigating factor when the facility or caregiver was responsible for the issuance of the erroneous order, prescription, individual care plan, or directive or knew or should have known of the errors and took no reasonable measures to correct the defect before administering care;
- (2) comparative responsibility between the facility, other caregivers, and requirements placed upon an employee, including the facility's compliance with related regulatory standards and the adequacy of facility policies and procedures, facility training, an individual's participation in the training, the caregiver's supervision, and facility staffing levels and the scope of the individual employee's authority and discretion; and
- (3) whether the facility or individual followed professional standards in exercising professional judgment.

SP1 and SP2 each worked in the AV's classroom and were responsible for supervision of the classroom at the time of the incident. SP1 and SP2 were each trained on the facility's policies, including the *Employee Handbook* and the Reporting of Maltreatment of Minors Act. SP1 and SP2 were 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 as it was a single incident, and the AV was not injured.

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 but not followed when staff persons did not complete a face to name count. The staff persons were retrained on policies.

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

SP1 and SP2 were not disqualified from providing direct care services as a result of the maltreatment determination in this report. However, SP1 and SP2 were each 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 and SP2 were each responsible for maltreatment is subject to appeal.

On March 8, 2024, the facility was issued a Correction Order for the violation outlined in this report.

Certification:

The information collection procedures followed in this investigation were pursuant to Minnesota Statutes, section 260E.30, subdivision 6, paragraph (c). All individuals that are subjects of data in this investigation have the right to obtain private data on themselves which was collected, created, or maintained by the Department of Human Services.