

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: 202310415

Date Issued: March 15, 2024

Name and Address of Facility Investigated:

Little Sprouts LLC
708 Parkway Avenue
Eagle Lake, MN 56024

Disposition: Maltreatment determined as to neglect of two alleged victims by the facility.

License Number and Program Type:

1115945-CCC (Child Care Center)

Investigator(s):

Danielle Morrison
Minnesota Department of Human Services
Office of Inspector General, Licensing Division
PO Box 64242
Saint Paul, Minnesota 55164-0242
danielle.morrison@state.mn.us
651-431-5647

Suspected Maltreatment Reported:

It was reported that while a staff person (SP) prepared to warm an infant's bottle in a cup filled with hot water, the cup spilled, and the water landed on two alleged victims (AV1 and AV2) which resulted in injuries to AV1 and AV2.

Date of Incident(s): December 11, 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 December 27, 2023; from documentation at the facility and medical records; and through five interviews conducted with one supervisory staff person (P1), three facility staff persons (the SP, P2, and P3), and AV1's family member (FM1).

AV2's family member (FM2) was notified however, s/he did not provide any information to this investigator.

AV1 was 12 months old and AV2 was 11 months old and both AV1 and AV2 were enrolled in the Infant Two classroom at the time of the incident.

The facility was in a building with two other businesses. The facility had two infant classrooms, one toddler classroom, and one preschool classroom. The Infant Two classroom had a counter that was approximately 25 inches deep and had a sink in it. There was also a microwave on the counter that was situated at the back of the counter and had approximately eight inches in front of it.

P1, P2, P3, and the SP each stated that to warm up bottles they placed a cup of water in the microwave, and once it was warmed up it was removed from the microwave, placed on the counter, and a bottle was placed inside of it. P2, P3, and the SP stated they warmed the bottles anywhere between two and three minutes. P2 and the SP each stated that they placed the cup on a washcloth.

The SP provided the following information:

- On December 11, 2023, the SP and P2 were working in the infant classroom. The SP prepared a bottle for AV2 and when it was ready the SP went to the microwave, pulled the cup of water out of the microwave, set it on a washcloth that was folded in half, and placed a bottle in it. At this time AV1 was trying to climb up the SP's right leg and AV2 was behind the SP. The SP bent down to move AV1, and it happened "so fast," but the SP thought s/he pulled the washcloth as s/he bent and the cup spilled. Water from the cup landed on AV1 and AV2.
- The SP grabbed AV1, who was crying "real hard," and started to undress him/her and told P2 it was hot water and asked P2 to check AV2. P2 showed the SP AV2's back so the SP had P2 take off AV2's clothes as well. The SP used the classroom's walkie talkie to contact P1 to come and assist with AV1. The SP said AV1's face and arm were red and starting to peel when P1 came into the classroom.
- The SP stated that P1 tried putting water on AV1 from the sink and then took AV1 with him/her out of the classroom and then the SP called FM1 and FM2 to tell them what had happened. The SP stated that s/he did not call 9-1-1. The SP then took a cold-water bottle and held it on AV2's back. AV2 had a bright pink rectangle on his/her back about one and one half by four and a half inches. The SP was not sure how long it took FM1 to arrive at the facility, but it took FM2 a "good fifteen minutes or so." FM2 arrived and the SP provided a blanket to cover AV2 up since his/her clothes had been taken off. FM2 left with AV2. The SP did not see P1 until after FM1 picked up AV1.
- AV2 returned the next day to the facility and FM2 told the SP the doctor said AV2's injury was like a "really bad sunburn." AV1 had not yet returned to the facility, but the SP heard that s/he had medicated bandages and the SP saw FM1 at the facility picking up his/her other child and FM1 showed the SP pictures of AV1's skin growing back and stated that AV1 was a "trooper through everything."

- On the day of the incident, the SP thought s/he had placed the cup where s/he “normally did.” The SP stated that s/he “sometimes” put the cup on a washcloth in case the cup overflowed, but “usually” the washcloth was open and not folded in half like on the day of the incident.
- After the incident, P1 brought in buckets that s/he used Velcro to secure them to the counter. Staff persons were told to place the cup in the bucket when warming up bottles so that if the cup did tip over the bucket would catch the liquid. Then P1 found waterless bottle warmers and the facility started using those. The SP stated that s/he cried over what happened and that s/he still had “nightmares” about it.

P2 provided the following information:

- On the day of the incident, P2 was working in the classroom with the SP. The SP placed the cup on the counter on a towel as P2 was walking around with another child. P2 bent to put that child down when s/he heard something drop and the SP “kind of scream” that s/he needed help. P2 did not see what happened but helped by removing AV2’s clothes while the SP removed AV1’s clothes.
- P2 said AV1 was “screaming” and AV2 made a “little bit” of sound. P2 saw that AV1 was “all red” on his/her right side from AV1’s head, arm, and torso. P2 saw AV1 had started to blister. AV2 had a triangle about an inch big on his/her mid back. After a minute or two, P2 said P1 was called to help with AV1, so P2 helped watch the other children in the classroom at that time.
- P2 stated the SP called FM1 and FM2 and they both arrived in approximately 20 minutes. P2 thought FM2 arrived first and then FM1 who took AV1 to the hospital.
- P2 stated after the incident, a tub was placed on the counter to put the cups in when warming bottles.
- The SP told P2 that s/he thought his/her clothing got caught on the towel because s/he did not remember bumping the cup with his/her elbow.

P1 provided the following information:

- Around 10:30 a.m. on the day of the incident, P1 was in his/her office and the SP communicated over walkie talkie that s/he needed help with AV1. P1 arrived in the classroom and AV1 was screaming. P1 took AV1 to put cold water cloths on his/her arm. P1 stated that AV1’s face and arms were red, but s/he did not remember if AV1’s chest was red. P1 had the SP call FM1 and P1 tended to AV1 until FM1 arrived. When asked by this investigator why 9-1-1 was not called, P1 stated that his/her reaction was to have the SP call FM1 and FM2.
- P1 said the SP and P2 tended to AV2, and the SP also called FM2. AV2 was not crying and had gotten a little bit of water on the bottom of his/her back.
- FM1 arrived and took AV1 to the emergency room and then was transported to a specialty burn unit at another hospital. FM1 told P1 that AV1 sustained second degree burns. AV1 was in the hospital “maybe

a day or two" and then was at home but had not returned to the facility because FM1 needed to change his/her bandages. FM2 took AV2 to the doctor and was told it was "like a sunburn."

- The SP told P1 that s/he put the cup for warming the bottle on a washcloth on the counter and then bent over to pick up AV1 who was clinging to the SP's leg and the SP's arm "must have bumped the cup" so it spilled. P1 said the SP "felt terrible" and had "sleepless nights" about what happened.
- Prior to the incident, P1 stated that an insurance company told him/her that crockpots and bottle warmers were not approved to warm up bottles. After the incident occurred, P1 got a bucket and used Velcro to secure it to the counter and then had staff persons place the cup in the bucket. After speaking with the facility's insurance company After the incident, the insurance company recommended to P1 that waterless bottle warmers should be used so P1 purchased those.

P3 provided the following information:

- P3 was not in the classroom at the time of the incident. When P3 returned to the classroom around 11 a.m., s/he asked the SP how things went when P3 was out of the classroom and the SP mumbled something so P3 asked again and then the SP said, "I burned them, [AV1] and [AV2], water fell on them."
- P3 asked more questions and gathered that the SP was warming up AV2's bottle and both AV1 and AV2 were at the SP's feet. The SP turned to pick up AV1 and move him/her, when the cup warming AV2's bottle knocked over, and the water inside spilled landing on AV1 and AV2. The SP removed AV1's clothes and then called P1 to come and help. P2 removed AV2's clothes to administer first aid. P1 took AV1 to the kitchen for colder water and the SP called FM1 and FM2.
- P3 stated that the cup was "normally" pushed back about an inch away from the wall. P3 stated that the SP put a towel underneath the cup so it did not overflow, and the SP could wipe the bottle off when s/he took it out of the cup.
- P3 stated since the incident, P1 purchased a bin to Velcro to the counter that the cup could be placed in so that if it did tip, the water was contained in the bin. However, after speaking with the facility's insurance company, P1 purchased waterless bottle warmers to use.
- P3 stated that the SP was "very distraught" about what happened. P3 stated that the SP asked several times, "I wonder how [AV1] is doing?" P3 said the SP was "beating [him/her]self" up over it.

On the morning of the incident, FM1 received a telephone call from a staff person at the facility letting him/her know what happened. FM1 arrived at the facility and was met by P1 who was not sure what exactly had happened at the time. FM1 took AV1 to the local hospital and then was transferred to a specialty burn unit at another hospital via ambulance. AV1 was discharged after two days, but still needed his/her dressing changed multiple times a day so s/he had not returned to the facility at the time this investigator spoke with FM1. FM1 planned to have AV1 return to the facility. When P1 followed up with FM1 s/he told FM1 that a cup was filled with hot water to warm up a bottle, and there was a rag underneath the bottle that got caught on a staff person's clothing and pulled the cup over.

AV1's *Medical Records* showed that s/he was admitted to a burn unit at a hospital on December 11, 2023, with second degree partial thickness burns to right side of face and scalp, right arm, and trunk covering 5% of his/her total body surface area. AV1 underwent daily dressing changes and debridement under sedation with the Pediatric Intensive Care Unit. AV1 was evaluated by Ophthalmology and there was no corneal involvement seen. AV1 was deemed safe to discharge home with family members when medically ready, no further medical work up was needed, and a five day follow up plan. AV1 was discharged on December 13, 2023, with topical ointment and over the counter pain relievers. AV1 was prescribed Oxycodone for as needed pain relief.

AV2's *Medical Records* showed that on December 11, 2023, s/he was admitted to the emergency department with a burn. AV2 had less than 1% total surface body area with peeling skin approximately one and one half centimeters (cm) in diameter in the mid back just above AV2's buttock area. Surrounding was a superficial first-degree burn approximately four cm by seven cm. AV2 was discharged the same day with over-the-counter medication as needed for pain relief.

The facility's *Risk Reduction Plan* referenced the facility's *Emergency and Accident Policy* which stated that, "Staff [persons] will not drink hot liquids when working around children," and referenced the facility's *Childcare Program Plan* that stated, "Children will be supervised at all times." Prior to the incident, there was nothing in the facility's handbooks, *Risk Reduction Plan*, or *Emergency and Accident Policy* regarding warming up bottles or how to prevent injury from devices used to warm food or beverages.

The facility's *Parent Handbook* stated, "In case of a medical emergency first aid will be administered by the staff [persons]. The [family members] will be notified as quickly as possible. If medical attention is required, the staff [persons] will call the local ambulance service, which will transport the child to the local hospital."

Relevant Rules and/or Statute:

Minnesota Rules 9503.0140, subpart 17 states in part that hazardous objects must be stored out of reach of children.

Conclusion:

A. Maltreatment:

Consistent information was provided that on December 11, 2023, the SP was preparing a bottle by placing a cup of water in the microwave and once heated up taking the cup out of the microwave, placing it on the counter, and putting a bottle in it. AV1 and AV2 were both near the SP and as the SP bent over to move AV1 to a different spot, the cup spilled, and the hot water fell on AV1 and AV2.

The SP undressed AV1 and P2 assisted with AV2. The SP used the walkie talkie to communicate with P1 that s/he needed assistance. P1 arrived at the classroom, applied cold water cloths to AV1's arms, and had the SP call FM1 and FM2. FM1 and FM2 arrived and took AV1 and AV2 respectively for medical attention. AV1 was seen at a local hospital and then transferred to a specialty burn unit at another hospital where s/he spent two days. AV2 was seen by his/her doctor and went home that same day.

AV1 sustained 2nd degree burns to his/her face and scalp, right arm, and torso. AV2 sustained a small red mark on the middle of his/her back.

Given that the SP, P1, P2, and P3 all provided consistent information with how staff persons warmed up bottles in the infant classroom which was a violation of Minnesota Rules 9503.0140, subpart 17; and that AV1 and AV2 sustained injuries, there was a preponderance of the evidence that there was a failure to protect AV1 and AV2 from conditions or actions that seriously endanger their 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. 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.

Although the SP was the staff person who prepared the bottle, given that s/he prepared the bottle in a manner in which s/he was trained, and that this was the facility practice as all other staff persons warmed bottles the same way, the SP was mitigated from responsibility of maltreatment of AV1 and AV2 and the facility was responsible for maltreatment of AV1 and AV2.

C. Serious Maltreatment:

The Office of Inspector General is required to evaluate whether substantiated maltreatment by a facility meets the statutory criteria to be determined as "serious."

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 maltreatment for which the facility was responsible was "serious" maltreatment. Although AV2 sustained superficial burns and did not require the care of a physician, AV1 sustained 2nd degree burns to his/her face and scalp, right arm, and torso requiring 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 found the SP followed the facility's policies and procedures, but changed the policy for warming up water for bottles to placing the cup in a bin that was secured to the counter.

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

On March 15, 2024, the license holder was ordered to forfeit a fine of \$5000 as a result of the substantiated maltreatment for which facility was responsible. The maltreatment determination and the Order to Forfeit a Fine are each 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.