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: 202400310

Date Issued: March 20, 2024

Name and Address of Facility Investigated:

Creme de la Creme Maple Grove
13001 62nd Place North
Maple Grove, MN 55369

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

License Number and Program Type:

1100327-CCC (Child Care Center)

Investigator(s):

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Suspected Maltreatment Reported:

It was reported that a staff person (SP) shook an alleged victim (AV).

Date of Incident(s): January 11, 2024 (Note: The Department of Human Services received the report on January 12, 2024, and assigned it to as a licensing complaint. On January 31, 2024, the report was reassigned as a possible maltreatment.)

Nature of Alleged Maltreatment Pursuant to Minnesota Statutes, section 260E.03, subdivision 15, paragraph (a), clauses (1) and (2); subdivision 18, paragraph (a); and subdivision 23, paragraph (a):

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.

"Physical abuse" means any physical injury, mental injury, or threatened injury, inflicted by a person responsible for the child's care on a child other than by accidental means. "Threatened injury" means a statement, overt act, condition, or status that represents a substantial risk of physical or sexual abuse or mental injury.

Summary of Findings:

Pertinent information was obtained during a site visit conducted on February 5, 2024; from documentation at the facility; and through nine interviews conducted with the AV's family members, management staff persons, staff persons, and the SP.

The facility was a large building that included three infant classrooms. Each classroom was equipped with video cameras used for continuous monitoring to ensure safety and security of the children.

The AV was three months old at the time of the incident and enrolled in the facility's Infant A classroom. The Infant A classroom had three bouncy seats for the infants. (Note: A bouncy seat is a piece of equipment for an infant. The bouncy seat has a fabric covered seat attached to a metal frame where an infant can securely play, relax, and bounce.)

Information received by the Department of Human Services stated that on January 11, 2024, the SP "self-disclosed" to a medical professional that s/he had "shaken" the AV on the morning of January 11, 2024. At that time, there was no information that the AV was injured, bruised, or hurt.

Video surveillance of the Infant A classroom on January 11, 2024, showed the following information:

- At 11:34:11 a.m., the SP sat on a rocking chair and the AV was in a bouncy seat on the floor at the SP's feet. The SP bounced the chair with his/her feet for approximately 25 seconds and then stood up and walked around the classroom.

- Between 11:34:45 and 11:36:25 a.m., the AV appeared to be crying. At 11:36:25 a.m., the SP sat back down in the rocking chair and rapidly bounced the AV's chair with his/her foot. The AV can be seen bouncing up and down with his/her head moving back and forth and lifting off the chair. The AV's head lifted off the bouncy chair six times. At 11:36:52 a.m. the SP stood up and went to the classroom telephone to make a telephone call. (Note: There is no audio to the video.)

- At 11:37:41 a.m., the SP picked the AV up, held the AV upright without supporting the AV's head and neck, patted the AV's back with an open hand, and vigorously bounced the AV in his/her arms for eighteen seconds. In those eighteen seconds, the AV's head bounced/shook back and forth thirteen times. Then the SP cradled the AV's head in his/her opposite arm and supported the AV's head while the SP swayed back and forth and sat down in the rocking chair with the AV. At 11:38:25 a.m., a staff person (P3) brought the SP a pacifier for the AV.

- At 11:39:15 a.m. the SP put the AV back into the bouncy chair, put the pacifier in the AV's mouth, and walked away. At 11:39:47 a.m., the AV spit the pacifier out of his/her mouth and was not crying. The SP walked to the side of the bouncy chair and put the pacifier back into the AV's mouth with enough force that pushed the bouncy seat down to the floor and the AV's legs kicked up. The SP held the pacifier in the AV's mouth and when s/he removed his/hand the AV spit the pacifier out and started crying. At 11:40:02 a.m., the SP pushed the pacifier into the AV's mouth while moving his/her hand in a fast side-to-side

motion causing the AV's head and body to move back and forth four times. The SP's action of pushing the pacifier into the AV's mouth was forceful enough to lift the front leg of the bouncy chair off the floor. At 11:40:16 a.m., the SP set the pacifier down next to the AV in the bouncy seat and walked away from the AV. The AV remained in the bouncy seat and crying.

The AV's family members (FM1 and FM2) stated that a facility management person (P1) notified them of the incident on February 2, 2024. FM1 and FM2 were concerned that they were not notified immediately but stated that they had not noticed any behavior changes or injuries to the AV between January 11 and February 2, 2024, and had no reason to take the AV to a medical professional. FM1 reviewed the facility's video footage of the incident and stated that it was "alarming" but that s/he thought the SP appeared to be "distracted" but not frustrated with the AV.

P1 and another management person (P2) provided the following information:

- On January 11, 2024, P1 and P2 were working in the facility's office when the SP came to the office and said that s/he wanted to go home because s/he "felt" like s/he was going to shake a baby. At that time, the SP left the building and went on his/her lunch break. When the SP returned to the facility after his/her break, P1 and P2 told the SP that s/he did not need to return to the facility that day.

- P1 and P2 each stated that they were "surprised" by the SP's statement but did not think that the SP had hurt an infant and neither went into the infant classroom to ensure that everything was alright in the classroom after the SP left for the day.

- According to P1 and P2, the SP had submitted his/her resignation the morning prior to the incident. P1 contacted the SP later that day and told the SP that s/he did not need to return to the facility to complete his/her scheduled shifts because of the SP's "threatened" statement about shaking an infant.

- On January 25, 2024, a representative from the Department of Human Services went to the facility regarding a possible "complaint." At that time, P1 was unaware that anything had happened in the infant classroom on January 11, 2024. P1 watched video from January 11, 2024, and saw the SP holding the AV without supporting the AV's head or neck. The SP bounced and the AV's head moved when the SP bounced the AV. P1 did not think that the SP's actions were "malicious" but stated that they did not follow the facility's policies on handling children.

- P1 was not familiar with the AV and had not worked with the AV so s/he was not aware of any behavioral changes or injuries to the AV. P2 had not noticed any behavioral changes or injuries to the AV.

A facility staff person (P3) stated that on the morning of January 11, 2024, s/he worked in the infant room with the SP. P3 did not remember seeing the SP holding the AV or treating the AV inappropriately. P3 stated that the SP appeared to be "tired" on the day of the incident but was not "frustrated." P3 had not noticed any behavior changes or injuries on the AV between January 11 and February 5, 2024.

A facility staff person (P4) stated that s/he typically worked in the infant classroom with the SP but was not at the facility at the time of the incident. When P4 returned to the facility on January 12, 2024, P2 told P4 that the SP "threatened" to shake an infant and that the SP would not be returning to the facility. P4 did not have any

information about the SP's actions with the AV. P4 worked with the AV from January 12 through February 2,

2024, and did not notice any behavioral changes or injuries to the AV.

A facility management person (P5) stated that on January 11, 2024, s/he was in P1's office when the SP returned from his/her break. The SP entered P1's office and was crying. P1 told the SP that s/he could go home for the day. P5 did not know why the SP was crying but thought that the SP was "stressed" and tired. Prior to the day of the incident, P5 observed the SP as a "caring" staff person who tended to each infant's needs immediately. P5 was not present when the SP talked to P1 and P2 but was told by P1 and P2 that the SP stated that s/he "felt like shaking a baby." On February 2, 2024, P5 watched the video from January 11, 2024. P5 stated that s/he saw the AV's head moving back and forth without any support from the SP. According to P5, the SP was not holding the AV's head "properly." P5 did not work in the infant room or with the AV so P5 was unaware if there had been any behavior changes or injuries to the AV.

A facility management person (P6) stated that on February 2, 2024, s/he reviewed the video from January 11, 2024. P6 identified the AV. P6 stated that the SP did not appear to be upset when s/he was bouncing the AV, but stated that the SP was not supporting the AV's head while s/he bounced the AV. P6 had not noticed any behavioral changes or injuries to the AV.

The SP provided the following information:

- The SP stated that on January 11, 2024, s/he was "frustrated and upset" while at the facility because other staff persons were being "rude" toward each other, there were "a lot" of babies crying at the same time, and the facility was "unorganized."

- The SP stated that the AV was "off" on the morning of the incident. The SP tried to comfort the AV by holding the AV in his/her arms and with a "normal" bounce while holding the AV. The SP did not notice that the AV's head or neck was not supported or that the AV's head was moving back and forth. The SP stated that s/he put the AV in the bouncy chair to comfort the AV, but the AV continued to cry so the SP bounced the bouncy chair harder to try to comfort the AV. The SP stated that s/he did not realize s/he was "vigorously" bouncing the AV.

- According to the SP, the AV used a pacifier that required the SP to put his/her finger through one end of the pacifier and hold it until the AV latched on to the pacifier. On the day of the incident, the AV was not latching on to the pacifier, so the SP moved the AV back and forth in the bouncy seat to comfort the AV. At that time, the SP realized that s/he was at his/her "breaking point" and needed a break.

- Prior to leaving the facility for his/her break, went to P1 and P2 and said that s/he needed a break because s/he felt like shaking an infant. When the SP returned to the facility after his/her break, P1 and P2 told the SP that s/he could have the rest of the day off.

- The SP stated that s/he was not trained on abusive head trauma or any policies while s/he worked at the facility. The SP stated that s/he "only" watched ten "very" long videos before working with the children.

- The SP stated that s/he was "comforting" the AV and that s/he did not think that s/he mishandled the AV or that s/he caused any injury to the AV.

The facility used the videos approved by the Department of Human Services for the required *Abusive Head*

Trauma training. Each staff person was required to complete a test after viewing the videos.

The Department of Human Services (DHS) has provided three videos on Abusive Head Trauma (AHT) which can be used for training of staff persons, but are not required when providing AHT training. https://mn.gov/dhs/partners-and-providers/licensing/child-care-and-early-education/centers/ The training videos are as follows:

- Never Shake: Preventing Shaken Baby Syndrome (Produced by the Missouri Children's Trust Fund, 7:48) https://www.youtube.com/watch?v=M3xytsg6oDo
- Shaken Baby Syndrome (Produced by TheDoctorsTV, 1:48) https://www.youtube.com/watch?v=THhFoYk7U40
- Forever Shaken (Produced by the Brain Injury Association of Nebraska, 33:17) https://www.bing.com/videos/search?q=https%3a%2f%2fwww.youtube.com%2fforever+shaken&view=detail&mid=29C2146EAC7A3D20C56B29C2146EAC7A3D20C56B&FORM=VIRE

The facility's personnel file showed that the SP received training on the facility's *Abusive Head Trauma* and the Reporting of Maltreatment of Minors Act on November 11, 2023. P1, P2, P3, P4, P5, and P6 were each trained on the facility's *Abusive Head Trauma* and the Reporting of Maltreatment of Minors Act prior to the incident.

Relevant Rules and/or Statutes:

Minnesota Rules, part 9503.0055, subdivision 3, item A, states that the license holder must have and enforce a policy that prohibits the subjection of a child to corporal punishment. Corporal punishment includes, but is not limited to rough handling, shoving, hair pulling, ear pulling, shaking, slapping, kicking, biting, pinching, hitting, and spanking.

Minnesota Statutes, chapter 245A.40, subdivision 5a, paragraphs (a) and (b) states before caring for children under school age, the director, staff persons, substitutes, and unsupervised volunteers must receive training on the risk of abusive head trauma during orientation and each calendar year thereafter; and abusive head trauma training under this subdivision must be at least one-half hour in length. At a minimum, the training must address the risk factors related to shaking infants and young children, means to reduce the risk of abusive head trauma in childcare, and license holder communication with parents regarding reducing the risk of abusive head trauma.

Conclusion:

A. Maltreatment:

The facility's video surveillance showed that on January 11, 2024, at 11:37:31 a.m., the SP picked the AV up and "vigorously" bounced the AV for eighteen seconds causing the AV's head to bounce back and forth thirteen times. The SP placed the AV in a bouncy seat and walked away from the AV. At 11:39:47 a.m., the SP tried to put the AV's pacifier into the AV's mouth and pushed the bouncy seat down with enough force causing the AV's legs to kick up. At 11:40:02 a.m., the SP pushed the pacifier into the AV's mouth and moved the AV's body in a fast side-to-side motion causing the AV's head to move back and forth four times and the legs of the bouncy seat to lift off the floor. The SP's actions were inconsistent with the standards of a professional caregiver in a facility licensed by the Department of Human Services; and were a violation of Minnesota Rules, part 9503.0055, subpart 3, item A.

FM1 and FM2 each stated that they had not noticed any behavioral changes or injuries to the AV between January 11 and February 2, 2024. In addition, P2, P3, P4, P5, and P6 each stated that they had not noticed any behavioral

changes or injuries to the AV.

Although there was no known injury to the AV, given that the AV was three months old, that the SP stated that s/he was "frustrated and upset" on the day of the incident, that the SP engaged in four incidents that placed the AV at significant risk including:

- Rapidly bounced the AV's chair with his/her foot causing the VA to bounce up and down moving the AV's head moving back and forth and lifting off the chair. The AV's head lifted off the bouncy chair six times;
- Picking up the AV, holding the AV upright without supporting the AV's head and neck, patting the AV's back with an open hand, and vigorously bouncing the AV for eighteen seconds causing the AV's head bounce/shake back and forth thirteen times;
- Putting the pacifier back into the AV's mouth with enough force that pushed the bouncy seat down to the floor and the AV's legs kicked up; and
- Then pushing the pacifier into the AV's mouth while moving his/her hand in a fast side-to-side motion causing the AV's head and body to move back and forth four times.

Therefore, there was a preponderance of the evidence that the SP's actions were not accidental and represented a substantial risk of physical injury to the AV. In addition, the SP's actions were a failure to supply the AV with necessary care and a failure protect the AV from actions that seriously endangered the AV's physical and mental health.

It was determined that physical abuse occurred ("Physical abuse" means any physical injury, mental injury, or threatened injury, inflicted by a person responsible for the child's care on a child other than by accidental means. "Threatened injury" means a statement, overt act, condition, or status that represents a substantial risk of physical or sexual abuse or mental injury).

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.

The SP was responsible for the care for the AV at the time of the incident. The SP was trained on the facility's *Abusive Head Trauma* and the Reporting of Maltreatment of Minors Act prior to the incident. 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 physical abuse and neglect for which the SP was responsible was not serious because there was no information that the AV sustained an injury. However, the maltreatment for which the SP was responsible was considered recurring because the SP engaged in four separate incidents that placed the AV at significant risk.

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 that their policies and procedures were adequate but not followed at the time of the incident. 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 March 20, 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.