

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: 202400263

Date Issued: March 29, 2024

Name and Address of Facility Investigated:

St James Community Child Care
500 3rd Ave S
St James, MN 56081

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

License Number and Program Type:

830968-CCC (Child Care Center)

Investigator(s):

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Suspected Maltreatment Reported:

It was reported that an alleged victim (AV) missed a community bus that drove him/her to another program. A family member (FM2) of another child drove the AV to the next bus stop to get on the bus.

Date of Incident(s): November 1, 2023 (Note: The Minnesota Department of Human Services was not notified of the incident until January 10, 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 a supervisory staff person (P1), two facility staff persons (P2 and the SP), and the AV's family member (FM1). Attempts were made via phone to contact and interview another supervisory staff person (P3), but P3 did not respond.

According to the AV's enrollment information, the AV was four years old and enrolled in the preschool one room at the time of the incident. FM2 was not listed as an emergency contact on the AV's enrollment information or authorization to release form and did not have a relationship with the AV or FM1.

Consistent information was provided that the AV went to a different preschool program for part of the day. The AV was picked up by a community bus that parked along the side of the building where the toddler room was located. The community bus pick up time was between 8:15 and 8:30 a.m. and the preschool one room ate breakfast during that time. On one previous occasion, the AV missed the bus, so P2, P3, and the SP decided that the AV would wait in the toddler room for the bus while the preschool one room was at breakfast.

FM1 stated on November 1, 2023, at 5 p.m., FM1 went to the facility to pick up the AV. A family member (FM3) of another child asked FM1 if the AV missed the community bus earlier that day. FM1 said s/he was not aware of it and FM3 told FM1 that s/he saw that FM2 brought the AV to FM3's children's bus stop. FM1 said that FM2 did not have permission to take the AV from the facility. FM1 emailed P1 about the incident.

P2 provided the following information:

- On the day of the incident, P2 worked alone in the preschool room and the SP worked alone in the toddler room. P2 dropped the AV off in the toddler room on the way to breakfast. On the way back from breakfast, P2 stopped by the toddler room and the SP said that the AV missed the community bus because the SP was in the bathroom assisting other children. FM2 drove the AV to the next bus stop so s/he was able to get to preschool.
- Later that day, at approximately 12:30 p.m., the AV returned to the facility from the other preschool program. The AV was "fine" and did not have any injuries.

P1 stated on November 2, 2024, FM1 emailed and notified P1 about the incident. P1 was not aware prior to the email. P1 spoke to the SP and reminded him/her that staff persons were not allowed to release a child to another person without permission from a family member. P1 spoke to FM2 and told FM2 that s/he was not allowed to drive the AV or any child that was not his/her own in his/her personal vehicle. FM2 told P1 that s/he was a supervisor for the community bus company and P1 said that did not matter because FM2 was not allowed to bring any child that was not FM2's in his/her personal vehicle. P1 also followed up with FM1 about the incident.

The SP provided the following information:

- On November 1, 2023, at approximately 8 a.m., the SP was alone in the toddler room. The SP did not remember how many children s/he had at that specific time but said s/he generally had nine or ten children in the toddler room. (Note: This was a violation of Minnesota Rules, part 9503.0040, subpart 1, which states that the minimum staff to child ratio for the toddler age category is one staff person to seven children.) P2 dropped the AV in the toddler room on the way to breakfast. The SP was assisting other children as it had been a "hectic" morning with drop offs. When the SP looked up, s/he saw the

community bus drive by the window. The SP opened the door and took a few steps to try to stop the bus but the bus did not stop. The SP then went across the room and into the hall, looked around the hall for another staff person to assist the SP, but did not see anyone.

- FM2 saw the SP out in the hall and went into the toddler room and spoke to the SP. FM2 told the SP that since s/he was a supervisor at the community bus company, s/he knew where the next bus stop was and that s/he could drive the AV to that stop to get on the bus. The SP knew that FM2 had a car seat that the AV was able to ride in, so the SP let the AV leave with FM2.
- Later that day, the SP told P2 and P3 about the incident. At approximately 12:30 p.m., the AV returned to the facility and the AV did not have injuries. The SP had not told FM1 about the incident but they texted about it the following day. The SP stated that "in hindsight" s/he should not have let FM2 take the AV to the bus stop.

According to the facility's attendance record, there were eight toddlers, not including the AV, in the toddler room at the time of the incident. (Note: Which was a violation of Minnesota Rules, part 9503.0040, subpart 1.)

According to *googlemaps.com*, from the facility to where the next bus stop was 0.7 miles and took two minutes to drive.

According to the facility's *Pick Up Procedures*, on the enrollment form, family members indicated two persons other than themselves who were allowed to pick up the child(ren). Valid picture identification was required for non-family members to take the child.

According to the facility's *Unauthorized Pick Up of A Child*, if an unauthorized person attempted to pick up a child, staff persons did not release the child. The staff person called a supervisory staff person and "never" left the child. The supervisory staff person then escorted the unauthorized person to the supervisor's office. The supervisory staff person called the family member's home and work phone numbers or any of the child's emergency back up phone numbers for assistance.

Facility documentation showed that all staff persons interviewed in this investigation, including the SP, received training on the facility's *Pick Up Procedures*, the facility's *Unauthorized Pick Up of A Child* policy, and the Maltreatment of Minor's Act prior to the incident.

Relevant Rules and Statutes:

Minnesota Rules, part 9503.0110, subpart 3, item G, states that the facility must have policies regarding procedures to follow if an unauthorized person attempts to pick up a child.

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 November 1, 2023, the AV missed his/her community bus. The SP allowed the AV to leave with FM2 to drive the AV to the next bus stop, which were violations of Minnesota Rules, part 9503.0110, subpart 3, item G; and Minnesota Statutes, section 245A.02, subdivision 18, and Minnesota Rules, part 9503.0045, subpart 1, item A.

Allowing a child to leave the facility in a vehicle with someone other than an authorized person, did not allow staff persons to be able to intervene in the event of an emergency or to protect the AV. 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. 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 classroom was over ratio at the time of the incident, the SP was trained on the facility's *Pick Up Procedures*, the facility's *Unauthorized Pick Up of A Child* policy, and the *Maltreatment of Minor's Act* prior to the incident. The SP was responsible for the care and supervision of the AV at the time of the incident and allowed the AV to leave with FM2 who was not authorized to take the AV. The SP being over

ratio in the classroom would not have impacted the SP's ability to prevent the AV from leaving the facility with FM2. Therefore, 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 statutory criteria to be determined as recurring or serious because it was a single incident for which the AV did not sustain an injury that required 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 that policies and procedures were adequate but not followed. The facility provided all staff persons with additional training on the policy regarding who children were allowed to leave the facility with.

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

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

On March 29, 2024, the facility was issued a Correction Order for the violations outlined in this report.

In addition, it was determined that facility mandated reporters had knowledge of the alleged incident and did not report the incident as required. The license holder was ordered to forfeit a fine of \$200 for failure to report maltreatment. The Order to Forfeit a Fine is 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.