MALTREATMENT INVESTIGATION MEMORANDUM
Office of Inspector General, Licensing Division
Public Information

Minnesota Statutes, section 626.557, subdivision 1 states, "The legislature declares that the public policy of this state is to protect adults who, because of physical or mental disability or dependency on institutional services, are particularly vulnerable to maltreatment."

Report Number: 202310089

Date Issued: April 5, 2024

Name and Address of Facility Investigated:

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

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

License Number and Program Type:

1100327-CCC (Child Care Center)

Investigator(s):

Judith Schwanke
Minnesota Department of Human Services
Office of Inspector General
Licensing Division
PO Box 64242
Saint Paul, Minnesota 55164-0242
judith.schwanke@state.mn.us
651-431-4033

Suspected Maltreatment Reported:

It was reported that an alleged victim (AV) was left in a preschool classroom without staff persons' (SP1 and SP2) knowledge or supervision for approximately four minutes.

Date of Incident(s): November 29, 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 17, 2023; from documentation at the facility; and through ten interviews conducted with two supervisory staff persons (P1 and P2), seven staff persons (P3, P4, P5, P6, P7, SP1, and SP2), and the AV's family member (FM).

The facility was a large building with many classrooms. The Preschool 2 classroom was located off a long hallway and at one end of the hallway was a doorway that led to the facility playgrounds. The Preschool 2 classroom was a rectangle with exit doors on both short ends of the room one door went outside and the other door led to the hallway. Off one side of the classroom was a bathroom for the children. Across the hallway from the Preschool 2 classroom were other classrooms. The classrooms had large windows that looked into the hallway.

The AV was three years old and enrolled in the Preschool 2 classroom at the time of the incident.

The FM stated that on November 29, 2023, while driving home from the facility, the AV told the FM that s/he went to the bathroom and when s/he came out "everyone was gone." Then a wo/man, who the AV did not know, found the AV and brought him/her to the class. Later that evening, the FM emailed the facility about what the AV had told him/her. On November 30, 2023, when the FM and the AV arrived at the facility, the FM talked with a facility supervisory staff person who was unaware that an incident had occurred. That staff person told the FM that s/he would look at camera footage and get back to the FM. Later that afternoon, the staff person called the FM and told him/ her that the previous day, at approximately 3:38 p.m., SP1, SP2, and the other children left the classroom without the AV. At 3:42 p.m., the AV exited the classroom bathroom and sat on a couch in the classroom. Then a staff person walked by the classroom and saw the AV sitting on the couch alone and brought the AV to the hallway. Then they met another staff person who brought the AV to his/her class outside. The supervisory staff person also told the FM that there were seven staff persons who knew the AV had been unsupervised but none of them told a facility management person.

The facility provided two videos of the incident. The videos were time stamped and did not have audio. The first video was seven minutes and eighteen seconds and was from a camera above one of the classroom doors. The second video was three minutes and forty-seven seconds and was from a camera located on the opposite wall from the first camera. The videos showed the following:

- At 3:35:19, the children moved around the classroom and near the classroom door that led to the hallway. Some children were putting on coats and hats and other children already had coats and hats on and were seated near the door. SP2 was not on camera but SP1 was and was putting on his/her coat.
- At 3:35:24, as SP2 opened the classroom door to the hallway and stood in the doorway toward the class. SP1 put on his/her coat.
- At 3:36:36, SP1 stood over a cart and wrote on a piece of paper on a clipboard.
- At 3:37:31, SP2 was in the doorway and children lined up from him/her. SP1 was at the end of the line further back in the classroom.
- At 3:37:39, SP2 turned and walked into the hallway, followed by the children, except the AV.
- At 3:37:40, SP1 had the clipboard in his/her hand and was writing on a paper on the clipboard.
- At 3:38:01, SP1 and the group of children walked off camera.
- At 3:38:03, SP1 walked out of the classroom with the clipboard and the video ended. (This was the end of video two

- At 3:42:08, the AV walked into view from the left side of the camera frame, from the direction of the classroom bathroom. The AV crossed the room and sat down in a chair near the classroom door.
- At 3:42:29, P3 entered the classroom and walked to the AV and squatted down. P3's back was to the camera. The AV shook his/her head from side to side. P3 held out his/her hand to the AV and the AV stood up.
- At 3:43:04, P3 and the AV walked out of view of the camera together.
- At 3:44:33, the AV walked into the classroom with P4 and another child. P4 put on a coat and the AV put on a coat and hat.
- At 3:46:39, the AV, P4, and the other child walked out of view of the camera and the video ended.

P1-P7 provided the following consistent information:

- P3 stated that on November 29, 2023, s/he walked down the hallway that led past the Preschool 2 classroom. As s/he walked past the room, P3 turned his/her head and saw the AV sitting alone on a child sized couch in the classroom. The AV was not crying and looked "confused." P3 entered the room and asked the AV his/her name but the AV did not respond. P3 told the AV his/her name and then asked the AV where his/her class and teacher were. The AV was "unresponsive" so P3 took the AV's hand and told him/her, "Let's go find your teacher."

- P3 and the AV walked out of the classroom, into the hallway, and met P5 there. P3 told P5 that s/he found the AV alone in the classroom. P3 was going to leave the AV with P5 but then P4 walked down the hallway toward P3, P5, and the AV. P3 stated that P4 called the AV by his/her name and asked what s/he was doing. P4 "volunteered" to take the AV to his/her class. P3 stated that s/he felt confident leaving the AV with P4 because s/he knew that P4 worked in the AV's classroom. P3 then left the facility for other duties.

- P4 stated s/he had been in a different room of the facility completing an assessment with another child from the AV's classroom. When the assessment was complete, P4 and the other child left the room and walked down the hallway toward the AV's classroom. There s/he met P3, P5, and the AV and asked the AV what s/he was doing. P5 told P4 that P3 found the AV alone in his/her classroom and P3 gave the AV to P4. The AV was not crying and did not say anything to P4. P4 took the AV and the other child into the classroom and helped the AV put on his/her outdoor clothing to go outside. Then P4, the other children, and the AV left the classroom and walked down the hallway toward the exit door to the playground where they met SP1, who had just come inside. P4 stated that SP1 was "flustered" and said, "Oh my gosh." SP1 seemed "surprised" that the AV was still inside. P4 told SP1 that s/he had gotten the AV from P3. Then P4, SP1, the AV, and the other child went outside.

- P6 worked with P5 in the classroom across the hallway from the Preschool 2 classroom. At snack time, between 3 and 3:30 p.m., s/he was talking with P5 and "looked over" and saw the AV and P3 walk out of the Preschool 2 classroom and wondered what they were doing. P6 stayed in the classroom and P5 went into the hallway. When P5 returned to the classroom, s/he wanted to call P7, who was on the playground, but did not have his/her phone number. P6 did not know at that time why P5 wanted to call P7, but s/he gave P5 his/her phone. Later that afternoon, when P5, P6, and the classroom children went out to the playground, P6 talked with P7 and learned that the AV had been left in the classroom.

- P5 stated s/he worked in a classroom across the hallway from the Preschool 2 classroom. At approximately 3:30 p.m., s/he saw P3 and the AV walk out of the AV's classroom. The AV did not look

scared. P5 walked into the hallway and asked, "What's going on?" and P3 told P5 that s/he found the AV alone in the classroom. P4 then walked down the hallway and asked why the AV was in the hallway. P5 told P4 that SP1, SP2, and the other children went outside. P4 took the AV and went into the AV's classroom and got him/her ready to go outside, while P3 walked toward the front of the facility and P5 went back to his/her classroom. P5 said s/he knew that P7 was outside on the playground, so s/he called P7 and told him/her that SP1 left the AV in the classroom. P7 told P5 that SP1 was coming inside to get the AV. Then P5 went back into his/her classroom.

- P7 could not recall the date or time but on the day of the incident in the afternoon, s/he was outside at the preschool playground when SP1, SP2, and the Preschool 2 children came out to the playground. P7 saw the Preschool 2 children line up at the fence but did not think that SP1 or SP2 did a name to face count before the group entered the playground because s/he did not see them do so. Between five and ten minutes later, P7 got a phone call from P5 and P6. P6 told P7 that the AV was inside so P7 went to the Preschool 2 group and told SP1 that the AV had been left inside. SP1 "got bright red" and "ran" inside the facility. P7 then saw SP1 and the AV return to the playground but did not talk with SP1 after that. The AV stood by SP1 and P7 asked the AV if s/he needed a hug. The AV told P7 that s/he was "sad," and "wanted" his/her mom. A couple of days later, SP2 told P7 that on the day of the incident the room was "chaotic" and as SP1 and SP2 were doing "name to face" count they did not know the AV had gone into the bathroom.

- P2 stated that on the evening of November 29, 2023, the FM sent an email to P2. In the email, the FM stated that the AV was upset because when s/he came out of the bathroom, his/her teachers and friends had left him/her alone. The FM wanted to know if the information was true because when s/he picked up the AV, no one told him/her that the AV had been left in the room. On November 30, 2023, P2 talked to SP1, SP2, and P3-P7, and learned that what the AV had told the FM was accurate. P2 then had the staff persons write statements regarding the incident. P2 watched video footage and saw that SP1 and SP2 left the room without completing a name to face count and then saw the AV walked out of the bathroom. SP2 was at the front of the line and should have completed the name to face count before leaving the classroom. SP1 and SP2 should have conducted another name to face count before the children entered the playground.

- P1 was not at the facility at the time of the incident and did not provide any information outside of what was shown in the video of the incident.

SP2 provided the following information:

- On November 29, 2023, between 3:30 and 4 p.m., SP2 was in the Preschool 2 classroom with SP1. The children were getting their things on to go outside. SP2 stood near the classroom door that led to the hallway. The children were instructed to sit near the door area once they had their "winter gear" on. SP1 was in the middle of the classroom, standing near the name to face sheet that was on a clipboard.

- SP2 asked SP1 if the group was "good to go," and SP1 told SP2 that they "were good to go." SP2 did not hear SP1 conduct name to face attendance but "thought" SP1 completed it because when the children were ready and SP1 said they were good to go, s/he "implied" that s/he had completed a name to face attendance. SP2 did not complete a count of the children at that point.

- Then SP2 led the children out of the classroom with SP1 at the end of the line. The group walked through the hallway and out to the playground. Once they were at the playground, neither SP1 nor SP2 conducted a name to face count and "just let" the children go play. When they were outside, P4 brought the AV out to the playground and told SP2 that the AV had been left in the classroom.

- Because SP2 was "floating around" and it was SP1's classroom, SP1 typically completed the name to face attendance. On the day of the incident, "every" child was "antsy," and SP1 "rushed" to get them outside. SP2 followed SP1's lead. SP2 should have "swept" the classroom, including the bathroom, and ensured that SP1 completed a name to face count and/or completed the name to face count him/herself before leaving the classroom. SP2 did not do this because s/he "clashed" with SP1 and "feared" him/her. Prior to the incident, when SP2 brought up ideas to SP1, SP1 told SP2 that it was SP1's classroom. SP2 stated that s/he had brought this up to P2 but was told to work it out with SP1.

SP1 provided the following information:

- On November 29, 2023, at approximately 3:30 p.m., SP1 and SP2 were in the Preschool 2 classroom and the children were getting their coats on to go outside. The children lined up at the classroom door. SP2 led the children into the hallway and SP1 "grabbed" the clipboard. SP1 "failed" to stop SP2 and conduct name to face attendance. SP1 should have told SP2 to stop and complete a name to face check before the group left the classroom.

- When the group arrived at the playground, SP1 completed a name to face check but "a mistake was made while conducting the name to face count when a child ran into the playground and had to come back to have his/her name called. SP1 placed a check mark by the AV's name when the group entered the playground but SP1 did not "actually" see the AV.

- When SP1 and SP2 were on the playground with the Preschool 2 children, P7 received a phone call from P6. Then P7 told SP1 that s/he left the AV inside and to go get the AV. SP1 went inside and saw the AV walking down the hallway with P4. SP1 hugged the AV and asked him/her if s/he was okay, and the AV nodded. Then SP1, the AV, and P4 went out to the playground. On the playground the AV stood next to SP1.

- Typically, before leaving the classroom, SP1 was at the front of the line with the roster and completed a name to face check. SP1 was not sure why SP2 was at the front of the line on the day of the incident.

- On the name to face roster, staff persons checked every child's name and placed a check mark on the roster to ensure the children were in line. Name to face checks were to be completed before leaving a classroom and arriving at the destination.

The *Child Supervision Record* policy showed that as children left the classroom to go to the playground, staff persons were to complete name-to-face before crossing the threshold out of the classroom and again as crossing the threshold into the playground. Staff persons were to make sure to look at each child's face and verify they were with the group instead of just counting children. After the transition, staff persons were to write the total number of children and staff persons at the bottom of the attendance roster.

The *Child Supervision Record (CSR: Name to Face), dated November 29, 2023,* showed that SP1 and SP2 left the classroom to go to the playground at 3:31 p.m. For "Check 1" and "Check 2" there were 17 check marks for the

children on the list, including the AV. The spots designated for totals and staff initials at the bottom of the *Child Supervision Record* were not completed.

The *Student Attendance Roll Call* policy showed that a name to face roll call must be performed before leaving an area and immediately upon arrival to a new area. Staff persons were to look at each child and verbally call out their name and mark each child on the form. Once the staff person was "certain" all children were present, the group proceeded to exit the area.

The facility's *Risk Reduction Plan* stated that all preschool children were supervised when using the bathroom and that staff persons take "roll" frequently and especially during transitions, using name to face recognition.

Facility documentation showed that SP1, SP2, and P1-P7 were trained on the facility's policies and the Reporting of Maltreatment of Minors Act 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, stated that a child must have supervision at all times and that supervision was 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 29, 2023, at 3:38 p.m., the AV was in the Preschool 2 classroom without the knowledge or supervision of a staff person for approximately four minutes, which was a violation of Minnesota Statutes, section 245A.02, subdivision 18, and Minnesota Rules, part 9503.0045, subpart 1, item A.

Neither SP1 nor SP2 completed a name to face check before leaving the classroom and going to the playground and were unaware that the AV was in the bathroom when they exited the room, 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. SP1 stated that s/he completed the name to face check as the children entered the playground, but SP1 did not "actually" see the AV when s/he put a check by the AV's name.

Video footage showed the AV exited the bathroom and sat on a couch in the classroom until s/he was found by P3. Although the AV was left in the facility classroom and found by a staff person, given that the AV was alone without staff persons' supervision or knowledge, staff persons were unable to intervene if the AV injured him/herself or in the event of an emergency or other hazards. Therefore, there was a preponderance of the evidence that there was a failure to supply the AV with the 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 were trained on the facility's *Child Supervision Record* policy, the *Student Attendance Roll Call* policy, the facility's Risk Reduction Plan, and the Reporting of Maltreatment of Minors Act.

SP1 and SP2 were each responsible for the care and supervision of the AV at the time of the incident and were each 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 and SP2 were responsible did not meet statutory criteria to be determined as recurring or serious because it was a single incident and the AV was not injured.

Action Taken by Facility:

The facility completed an internal review and determined that their policies were adequate but not followed. Staff persons were retrained on proper name to face procedures and the Reporting of the Maltreatment of Minors. SP1 no longer worked at the facility.

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.

Minnesota Statutes, section 260E.06, subdivision 1, requires mandated reporters at a facility to immediately report suspected maltreatment. This investigation determined that five staff persons failed to report suspected maltreatment as required. A letter from DHS was sent to each of these individuals regarding their failure to report the suspected maltreatment and potential consequences for future such failures.

On April 5, 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.