

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: 202400354

Date Issued: April 17, 2024

Name and Address of Facility Investigated:

New Horizon Academy
328 Kutzky Court NW
Rochester, MN 55901

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

License Number and Program Type:

1079853-CCC (Child Care Center)

Investigator(s):

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Suspected Maltreatment Reported:

It was reported that an alleged victim (AV) sustained a dislocated elbow when a staff person (SP) pulled the AV to his/her feet by one arm, handled the AV in a rough manner, and "flicked" the AV's face.

Date of Incident(s): January 10, 2024

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 January 24, 2024; from documentation at the facility and medical records; and through four interviews conducted with the AV's family member (FM), the SP, and two supervisory staff persons (P1 and P2).

The AV's enrollment documents showed the AV was two years old and enrolled in the Toddler B classroom at the time of the incident.

The Toddler B classroom had a reading area and near the reading area was a diaper changing table. There was a wall phone in the classroom that was used to call out, call other classrooms, and/or other staff persons in the facility. The facility had video cameras in the classroom that provided recorded footage.

The FM stated that on January 10, 2024, the facility called another family member of the and said that the AV was on the changing table when the SP pulled him/her up. The AV started to cry and was now not moving his/her left arm. The FM took the AV to a local emergency room where the AV was "fixed" and within 15 minutes of treatment was "pain free." The AV had no further issues.

The video footage of the incident was 20 minutes. The video was time stamped and did not have audio. The video provided the following information:

- At 8:50 a.m., six children and the SP are visible. The AV played on the floor in the reading area while the other children were engaged in play throughout the classroom.
- At 8:54 a.m., the SP placed a child on the changing table and began to change his/her diaper. The AV was alone in the reading area looking at a book on his/her lap with his/her back towards the shelf. (Note: Dividing the reading area from another play area was a toy shelf. The back of the shelf was towards the reading area. Children could stand play all around the shelf.)
- At 8:59:28 a.m., a child pushed a toy off of the shelf and the toy hit the AV's back and fell to the floor. The AV picked up the toy and put it back on the top of the shelf. The child again pushed the toy off of the shelf and it fell hitting the AV in the back. The AV picked up the toy and attempted to place it on top of the shelf, but it fell to the side of the shelf.
- At 8:59:50 a.m., the SP then walked to the reading area. The AV looked up at the SP and the SP swept the fingers of his/her right hand in a downward motion over the AV's left eyelid and cheek. Then the SP used her right hand and pulled the AV from a sitting position to a standing position by pulling on the AV's left arm while the SP grabbed a doll off of the AV's lap with his/her left hand. The AV then took a hold of the doll, and the SP grabbed the doll from the AV's hand. The AV and the SP stood facing each other when the SP took two steps forward, knocking the AV to the floor landing on his/her back and buttocks. The SP then grabbed the AV underneath his/her arms and roughly picked the AV up to a standing position.
- At 9:00 a.m., the AV bent over, the SP grabbed the back shoulder of the AV's sweatshirt and pushed the AV forward, pointing to the toy on the floor. The SP then held the AV's right hand, and they picked up the toy together and placed it on the top of the shelf. Then the SP walked to the changing table and had his/her back to the AV as the AV remained standing next to the shelf crying.
- At 9:00:34 a.m., the SP turned around and faced the AV and the AV turned toward the SP and

- continued to cry. It appeared the SP talked to the AV.
- At 9:00:56 a.m., the SP walked to another child, picked him/her up under the arms and placed him/her on the changing table. While changing that child's diaper, the SP appeared to talk with the AV, as the AV continued to cry.
 - At 9:01:23 a.m., the AV grabbed at his/her left elbow and hugged it to his/her body.
 - At 9:02:23 a.m., the SP placed the child on the floor and walked to the AV. The SP squatted down, took hold of the AV's forearms, and pulled them out from his/her body. Then the SP placed his/her hands on the AV's shoulders and moved/squeezed his/her fingers over the area. The AV had stopped crying but started to cry again. The SP let go of the AV and wiggled his/her fingers and attempted to have the AV wiggle his/her fingers. Then the SP moved/squeezed the AV's shoulders again and then grabbed the AV's arms and moved/held them behind the AV's back. The SP let go of the AV's arms and the AV dropped them to his/her sides. The SP grabbed the AV's arms again and lifted them over the AV's head.
 - At 9:03:12 a.m., the SP scooped up the AV, carried him/her to the changing table, and lay the AV down on the changing table. After the SP changed the AV's diaper, s/he motioned for the AV to sit up. The AV held onto the edge of the changing table with his/her right arm and attempted to pull him/herself up to a sitting position but was not successful. The SP placed a hand on the AV's back and assisted him/her to a sitting position.
 - At 9:05:12 a.m., the SP touched/squeezed the AV's shoulders, wiggled the AV's left arm in an up and down and back and forth motion, and then wiggled the AV's right arm in a back-and-forth motion. Then the SP lifted the AV off the changing table and stood him/her on the floor. The AV cried and turned around while the SP used an iPad.
 - At 9:06:21 a.m., the AV walked to another shelf and the SP motioned to the AV to pull down the bottom portion of his/her pant leg. The AV attempted with both hands but could not and cried harder. Then the AV reached for his/her left elbow. The SP walked to the AV, pulled down his/her pant leg, and then walked to the changing table. The AV walked away and lifted his/her left arm and continued to cry. The AV stood and cried off and on for the remainder of the video.
- (Note: There were multiple licensing violations observed in the video regarding diaper changing.)

The facility used ProCare [a mobile application (app) platform used to communicate with families and streamline administrative functions]. Facility app entries showed the following information:

- On January 10, 2024, at 10:01 a.m. there was a message sent from the toddler classroom (the SP stated s/he sent a message to the FM) to the FM that stated the AV had been "favoring" his/her right arm that morning and his/her left arm seemed to be causing him/her "discomfort." Since approximately 9:35 a.m., the AV had not been using his/her left arm and was "emotional" when the SP asked the AV to use his/her left arm. The SP wrote that the AV's left arm looked "slightly swollen," and the AV was given comfort and an ice pack.
- At 11:35 a.m., P2 sent a message to the FM that stated the AV "cried" when P1 touched his/her arm. P2 thought it was in the AV's "best interest" to have the AV seen by a doctor and they were "looking into the situation" to see what happened.
- At 4:36 p.m., the FM sent a message to the facility that stated that the AV was seen at the emergency room and was diagnosed with nursemaid's elbow. The elbow was "reduced instantly" and the AV was much better.

Documentation from the emergency room dated January 10, 2024, at 4:47 p.m., stated that the AV would not "fully move" his/her left elbow and was treated for "radial head subluxation" (nursemaid's elbow). The AV was given ibuprofen for pain and the "radial head" was "relocated." The AV used his/her left arm without difficulty and was sent home with no further treatment necessary.

(Mayoclinichealthsystem.org showed that nursemaid's elbow is a common injury to children one to four years of age and occurred when the "annular ligament in the elbow is displaced by being pulled." If nursemaid's elbow was suspected, medical attention should be sought "immediately.")

P1 and P2 provided the following consistent information:

- P1 stated that on January 10, 2024, at approximately 9:15 a.m., s/he went into the Toddler B classroom and asked the SP if s/he needed anything. The SP told P1 that the AV "was not using" his/her left arm and was crying. P1 "gently touched" the AV's left arm and the AV cried. P1 asked the SP if s/he lifted the AV by his/her arm, if the AV "dropped" to the floor while the SP had been holding his/her hand, or if another child pulled the AV's arm which would have caused the AV's arm to be "dislodged." The SP told P1 that s/he lifted the AV correctly but was not sure if the AV fell on it or if another child had pulled it.
- Then P1 left the classroom and called the FM and left a message. P2 arrived at the facility and P1 told P2 about the AV's arm. Then P1 went back to the classroom and told the SP that s/he left a message for the FM and asked the SP to message the FM via the iPad. The SP started crying and told P1 that s/he had not been "honest" and that s/he had been "frustrated" during diaper changes and lifted the AV by one arm. P1 left the classroom and waited to hear from the FM.
- P2 was not at the facility at the time of the incident but arrived between 9:30 and 10 a.m. When P2 arrived, P1 told P2 that the AV was not using his/her left arm. P1 watched video footage of the Toddler B classroom but the video was "zoomed in" and P2 did not see anything that caused concern.
- At approximately 11:35 a.m., P2 created a message to the AV's family members in the app. Later in the day, P2 watched the video zoomed out and was "stunned" by the SP's actions because the SP "always" made sure s/he was "doing the right thing." P2 was "surprised" that the SP did not follow the dislocated elbow training s/he received at orientation. P2 did not see the AV do anything that would have caused the SP to react as s/he did. At the time of the incident, the room seemed "very well mannered" and "contained."
- Prior to this incident, P1 and P2 did not have concerns regarding the SP's interactions with children.

The SP provided the following information:

- On January 10, 2024, between 8:45 and 9:30 a.m., the SP was in the Toddler B classroom changing diapers while the children had "free play." It was "chaotic," and the children were not listening. The SP played a clean up song and asked the AV to help "clean up." The AV "got emotional," and the SP was not sure if another child hit the AV or threw something at the AV. The SP asked the AV to get up, but the AV did not answer or respond.
- Then the SP went to the AV and said that s/he was going to help the AV's "body." The SP "grabbed" the

AV's arm instead of his/her torso and "lifted" and "moved" the AV. The SP "realized immediately" that s/he made a "mistake" and stated s/he knew not to "grab" children and "should have used more verbal redirection."

- The SP realized "right away" that "something was really wrong." The AV's left arm "went limp" and s/he was crying a lot." The SP then "touched" the AV's left arm to "gauge" what was wrong with the AV and then the SP got an ice pack for the AV's arm.
- The SP created a message in the app to the FM that the AV was "emotional" and "favoring" one arm. The SP stated s/he omitted that s/he was "likely the one" who caused the AV's injury. The group proceeded through the day, and it was "difficult" for the AV to use an instrument, clap, or "basically do anything with the arm." The AV left the facility in the afternoon at snack time.
- The SP did not recall moving his/her hand down the AV's face.
- The SP stated that during orientation to the facility, s/he received training regarding nursemaid's elbow. The training showed that children should be lifted by the torso because ligaments in the arms were not fully developed yet.

The facility used a video titled "*Preventing Dislocated Elbows*" to train staff persons. The video was two minutes and 2 seconds long and featured a medical professional demonstrating the proper and improper way to lift a child. The video showed that staff persons should never "grab, drag, pull, yank, swing, or lift" children by their arms or wrists.

The facility's *Positive Behavior Guidance Policy* stated that staff persons developed a trusting relationship with children by using a "nurturing touch," and that staff persons were never to use any type of physical or verbal punishment.

The facility's prohibited regulations included, but were not limited to, rough handling, shoving, shaking, excessive tickling, slapping, kicking, biting, pinching, hitting, spanking, and pulling arms, hair, or ears.

P1, P2, and the SP each received training on the reporting of Maltreatment of Minors Act, the facility's *Positive Behavior Guidance Policy*, the *Preventing Dislocated Elbows* video, and prohibited actions.

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.

Conclusion:

A. Maltreatment

The SP stated and the video showed that on January 10, 2024, at approximately 8:50 a.m., the AV was seated on the floor when the SP walked to the AV, pulled the AV to a standing position by pulling on his/her left arm and engaged with the AV in physical manner. The AV sustained a dislocated left elbow. Although it was alleged that the SP "flicked" the AV's face, the video showed that the SP moved his/her fingers down the AV's face which did not appear to be a "flicking motion."

The SP's actions of pulling the AV's left arm to lift him/her to a standing position and handling the AV in rough manner that included knocking the AV over onto the floor, was inconsistent with the standards of a professional caregiver licensed by the Department of Human Services and were violations of Minnesota Rules, chapter 9503.0055, subdivision 3, item A.

At the time of the incident, the AV was not a danger to him/herself or others and in fact was sitting in the reading area looking at a book so did not require physical intervention. The SP's actions were not accidental. Therefore, there was a preponderance of the evidence that the SP's actions of grabbing, pulling, and moving the AV by the arm and engaging with the AV in a rough manner was a failure to supply the AV with necessary care, a failure to protect the AV from conditions or actions that seriously endangered the AV, caused injury to the AV, and represented a substantial risk of 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).

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).

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 and supervision of the AV at the time of the incident and was trained on the facility's *Positive Behavior Guidance Policy*, the *Preventing Dislocated Elbows* video, and the Reporting of Maltreatment of Minor's Act.

The SP was 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 and physical abuse for which the SP was responsible was not "recurring" because this was a single incident that met two definitions of maltreatment but was "serious" because

the AV sustained a serious injury (dislocated elbow) and required the care of a physician.

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 conducted an internal review and determined their policies were adequate but not followed by the SP. 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 April 17, 2024, the facility was issued a Correction Order for the violation outlined in this report, for failing to wash children's hands and staff person's hands after diaper changes, and for failing to comply with diaper changing procedures as required.

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.