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: 202403120

Date Issued: June 14, 2024

Name and Address of Facility Investigated:

Creative Kids Academy, Inc.
1135 W. Highway 10
Anoka, MN 55303

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

License Number and Program Type:

1053441-CCC (Child Care Center)

Investigator(s):

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Suspected Maltreatment Reported:

It was reported that an alleged victim (AV) was left unsupervised in a classroom for approximately seven minutes.

Date of Incident(s): April 9, 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 April 18, 2024; from documentation at the facility; and through four interviews conducted with two facility staff persons (SP1 and SP2), an administrative staff person (P1), and another child's parent (CP).

The AV was 16 months old and enrolled in the toddler classroom at the time of the incident.

The facility was located in a commercial area on a busy street. The toddler playground was located next to the entrance and parking lot at the back of the facility. The toddler classroom was a large classroom located in a corner of the facility. A counter ran along one wall. Tables and short bookcases holding toys and books were placed around the classroom. A half-wall, which had a half-door, separated the classroom from the main hallway. Another door in the classroom opened onto a "breeze way" area that had a second door opening onto the toddler playground. Information was provided that at the time of the incident, all of the classroom doors were closed and the AV was unable to open the doors.

The CP stated that on the day of the incident, at approximately 9:15 a.m., s/he arrived at the facility to drop off his/her child (C) in the toddler classroom. As s/he drove into the facility's parking lot, the CP noticed that SP1 and SP2 had the toddler children on the playground. When the CP and the C entered the toddler classroom to drop off items, the CP saw a facility maintenance person (MP), who told the CP that the AV was sitting in a corner of the classroom playing. The AV was not crying and "seemed fine." The CP stated that s/he went outside and told SP1 and SP2 that the AV was unsupervised in the classroom. SP1 and SP2 were "very shocked" and SP1 ran back to the classroom to get the AV.

SP1, SP2, P1, and the facility's documentation provided the following information:

- At the time of the incident, SP1 and SP2 worked in the toddler classroom with nine children. At approximately 9:10 a.m., SP1 and SP2 assisted the children with putting on their coats prior to going outside to the playground. SP2 believed that prior to going outside, SP1 did a head count of the children. SP2 believed that they "blanked" on the AV and left him/her unsupervised in the classroom. SP1 stated that it was "chaotic" as they assisted the children with their coats and led them to the breezeway and then to the playground. They took towels with them so that they could wipe rainwater off the riding toys on the playground. SP1 then took the towels to the breezeway and met the CP bringing the C out to the playground. The CP told SP1 that the AV was unsupervised in the classroom so SP1 went to the classroom and found the AV in the play kitchen area. The AV had his/her coat on but had taken off his/her shoes. The AV smiled at SP1 who then put the AV's shoes back on his/her feet before taking the AV to the playground.

- P1 stated that s/he was walking through the toddler classroom when s/he saw SP1 putting the AV's shoes on so s/he could go outside to the playground. SP1 told P1 that the CP found the AV unsupervised in the classroom and then told SP1 and SP2. P1 ensured that all of the other children were with the group on the playground and then telephoned another administrative staff person (P2) and told him/her about the incident. P1 and P2 then talked to SP1 and SP2 about the incident and were told that SP1 and SP2 did not do a head count when they went outside to the playground. SP1 believed that s/he would have counted the children when s/he returned to the playground after s/he put the wet towels in the breezeway, but the CP told him/her about the AV before s/he could count the children. P1 telephoned the FM to tell him/her about the incident. P1 estimated that the AV was unsupervised for approximately seven minutes. SP1 believed the

  AV was unsupervised for approximately six minutes and SP2 believed the AV was unsupervised for

approximately five minutes.

- SP1 stated that they typically did a head count of the children each time they transitioned from one area to another. They also counted the children every 30 minutes and documented the number of children in the classroom at the time on the classroom attendance sheet.

- While the AV was able to crawl, s/he was just beginning to walk and would be unable to open any of the doors to leave the classroom. Consistent information was provided that the AV did not sustain any injury during the incident. After the incident, all of the staff persons were retrained on the facility's safety and supervision policies.

According to the facility's *Head Count Tracking* form, on April 9, 2024, the AV arrived at the facility at 8:43 a.m., and the C arrived at the facility at 9:16 a.m.

According to the facility's *Risk Reduction Plan* and the facility's supervision policies, when the staff persons transitioned children from one area to another, they were to use a headcount sheet to count the children. During transitions, the staff persons were to count the children before and after each transition, as well as every 30 minutes. All children were to be within sight and hearing of the staff persons at all times.

Facility documentation showed that SP1, SP2, and the P each received training on the Reporting of Maltreatment of Minors Act and on the facility's policies prior to the incident.

Relevant Rules and/or Statutes:

Minnesota Statutes, section 245A.02, subdivision 18, and Minnesota Rules, part 9503.0045, subpart 1, item A, state 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:

On April 9, 2024, SP1 and SP2 worked in the toddler classroom with nine children. At approximately 9:10 a.m., SP1 and SP2 assisted the children with putting on their coats and then took the children outside to the playground. When they arrived at the playground, they used towels to wipe down the riding toys. At approximately 9:15 a.m., as SP1 took the towels back into the facility, the CP brought the C onto the playground and told SP1 that the AV was in the toddler classroom unsupervised. SP1 returned to the classroom and then took the AV to join the other children on the playground. Neither SP1 nor SP2 realized the AV was not with the group until the CP told them the AV was in the classroom. Leaving the AV unsupervised in the classroom for approximately five to seven minutes was a violation of Minnesota Statutes, section 245A.02, subdivision 18, and Minnesota Rules, part 9503.0045, subpart1, item A, and of the facility's policies. The AV did not sustain any injury while s/he was unsupervised.

Although the AV was not injured, given that SP1 and SP2 each failed to ensure that all of the children were on the playground once the group had completed its transition from the classroom, and that the AV, who was sixteen months old was left alone in the classroom for five to seven minutes without any staff person's knowledge which

did not allow for a staff person's intervention in the event of any emergency, there was a preponderance of the evidence that there was a failure to supply the AV with necessary care required for his/her physical or mental health and a failure to protect the AV from conditions that seriously endangered his/her physical or mental health.

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:
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> (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;
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> (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 each responsible for the supervision of the AV at the time of the incident and were trained on the Reporting of Maltreatment of Minors Act and on the facility's policies, including those regarding the supervision of children, prior to the incident.

SP1 and SP2 were 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 did not sustain any 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 the facility's policies were adequate, but were not followed by the staff persons. SP1 no longer worked at the facility. SP2 received retraining on the facility's policies.

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.

On June 14, 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.