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: 202403013

Date Issued: June 28, 2024

Name and Address of Facility Investigated:

Tutor Time of Brooklyn Park
9700 Schreiber Terrace North
Brooklyn Park, MN 55445

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

License Number and Program Type:

License number-830829 (Child Care Center)

Investigator(s):

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Suspected Maltreatment Reported:

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

Date of Incident(s): April 3, 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 16, 2024; from documentation at the facility; and through six interviews conducted with the AV's family member (FM), a community person (CP), two facility supervisory staff persons (P1 and P2), and facility staff persons (SP1 and SP2).

The facility was a stand-alone building with two outdoor playgrounds. Inside were several classrooms connected by a hallway, including two toddler classrooms. The Toddler 1 classroom was rectangular with a door with a large window to the hallway on one end. At the opposite side of the room was a door that led to the preschool playground and to the right and down a sidewalk was the toddler playground. The preschool and toddler playgrounds were separated by a chain link fence and gate. In the corner of the classroom, above the door to the playground, was a video camera. Along one wall of the room were three large windows that looked out to the hallway and below the windows were child sized furniture including a couch and chair. At the end of the hallway was a set of doors that led to the toddler playground.

Facility documentation showed the AV was eighteen months old at the time of the incident and enrolled in the Toddler 1 classroom.

The FM stated that on April 4, 2024, s/he was notified by P1 that staff persons did not practice "face to name" procedures and the AV had been "accidentally left" in the classroom for approximately six minutes. Since the incident, the AV was "great," and was "probably" too young to realize that s/he had been left. The FM did not have prior concerns regarding the facility and was "happy" with the way leadership handled the incident.

The CP provided the following information:

- The CP could not recall the date, but at approximately 4:30 p.m. on the day of the incident, s/he arrived at the facility to pick up his/her child. The CP walked down the hallway to the playground and looked through the hallway window into the Toddler 1 classroom. The CP saw the AV seated in a chair with his/her "outside gear" on. The AV did not seem upset and was "bopping" his/her leg on the floor.

- The CP walked to another window and looked in but did not see a staff person in the room. Then the CP walked down the hallway and out the doors to the toddler playground. The CP held the door open and asked if his/her child was on the playground. An unknown staff person told the CP that his/her child was in another classroom.

- Then the CP told the staff person that there was a child in the toddler room by him/herself. The staff person said, "Oh my gosh, what?" and the CP repeated what s/he said. The staff person said, "Oh my gosh, [s/he] must have snuck back in."

- The staff person then went into the facility. The CP also went inside, picked up his/her child in a different classroom, and left the facility. Approximately 30 minutes later, the CP called the facility and spoke with P2. The CP told P2 what had happened. P2 thanked the CP and told him/her s/he would follow up.

P1, P2, and an *Incident Report Form* provided the following consistent information:

- On April 3, 2024, at approximately 5:30 p.m., P2 received a phone call from the CP who said that s/he had "peeked" in the Toddler 1 classroom and saw the AV sitting by him/herself so s/he walked out to the playground and told a staff person (later identified as SP1) that s/he had noticed a child alone in the

room. SP1 then went inside to get the AV. The CP did not know how long the AV was in the room alone and wanted to be sure s/he was "okay."

- P2 told the CP that s/he would "look into it," hung up with the CP, and "immediately" called P1 and explained to him/her what had happened. By the time P2 was off the phone, SP1 had left the facility. P2 asked SP2 if "something had happened" and SP2 told P2 that a child had been left in the classroom for approximately two to three minutes. Then P2 called P1 and told him/her what SP2 had said.

- The next day, P1 and P2 watched video footage from the incident. P1 and P2 both stated that on the video they saw SP1 at the door to the preschool playground at the front of the group. SP1 held the door open with a clipboard in his/her hand, and "guided" the children outside. The AV started to walk to the preschool playground and SP1 took the AV's hand and guided him/her toward the toddler playground. The AV walked back into the classroom "under" SP1's "nose" and was not seen by either SP1 or SP2. SP2 was at the end of the line and carried two children out and the door shut. No face to name was completed by either SP1 or SP2 as the children exited the classroom. After the group left the classroom, the AV cried near the door and then walked over to a small couch and sat down. The CP walked by the classroom and went outside. Then SP1 entered the classroom and took the AV and left the classroom.

- P1 and P2 stated that the video showed the group went outside at 4:20 p.m., and SP1 entered the classroom at 4:26 p.m. The AV was unsupervised for six minutes.

- P1 and P2 stated that "face to name" attendance was taken at "every door frame or gate" on the *Face to Name Transition Sheet*. Staff persons called a child's name as they crossed the threshold and then made a check mark near the child's name on the face to name sheet. When they reached the destination, the staff person called the child's name again and circled the checkmark when they saw the child.

- SP1 and SP2 were each responsible to complete face to name attendance as they left the classroom and at the gate to the toddler playground.

SP1 provided the following information:

- SP1 could not recall the date but at approximately 4:30 p.m. on the day of the incident, SP1 and SP2 got the children ready to go outside. As the group went out the classroom door to the playground, SP1 held the door open as the children walked out and SP2 was at the end of the line holding "some" children who could not walk.

- SP1 did not complete a face to name check as the group left the classroom because it was "overwhelming" to get the children ready to go outside and out the door while working with SP2, who was a new staff person.

- When SP1 "thought" everyone was outside, s/he shut the door and walked to the toddler playground gate. SP1 completed a face to name check on the *Face to Name Transition Sheet* at the toddler gate and "thought" s/he saw the AV.

- SP1 was in the toddler playground, standing near the doors when the CP came out and told him/her that the AV was inside the classroom. SP1 "apologized" to the CP and left the playground and went to the Toddler 1 classroom and saw the AV sitting on a couch as "chill as can be." SP1 took the AV's hand and

walked with him/her to the playground and the AV played.

- SP1 stated s/he was trained to complete face to name attendance when the group transitioned outside and inside.

SP2 provided the following information:

- SP2 could not recall the date but at approximately 4:30 p.m. on the day of the incident, SP1 and SP2 put on the toddlers' things to go outside. SP1 carried one child, the clipboard with the *Face to Name* sheet, and stood by the door and "called names." The AV cried because s/he did not want to go outside, and it was a "struggle." The AV went out and as they were trying to get others out, the AV "must have turned around and went [*sic*] back inside." SP2 was at the back of the line and carried two children out the door.

- When SP2 arrived at the gate to the toddler playground, s/he did not "think" SP1 completed face to name attendance at the gate.

- Once on the playground, SP2 put down the children s/he carried and talked with SP1. Five to fifteen minutes later, the CP came outside and asked if they knew there was a child inside. Immediately SP1 left the playground and came back out with the AV. SP2 said the AV cried when s/he got to the playground because s/he did not want to be outside.

- SP2 stated s/he thought SP1 "accidentally forgot to say a name" when doing the face to name procedure.

- During his/her training, SP2 was shown how to complete a face to name sheet. SP2 stated s/he did not know where and when face to name counts were to be completed.

The Fa*ce to Name Transition Sheet,* dated April 3, 2024, showed that eleven children, including the AV, transitioned from the Toddler 1 classroom to the playground at 4:20 p.m. with a check mark and a circle around each checkmark. The Face to Name Transition Sheet did not show who completed the checks.

The facility's *Child Supervision Procedure* showed that children "must be supervised, in the direct line of sight and within earshot" of a staff person "at all times."

The facility's *Face to Name Procedure* showed that staff persons completed *Face to Name Transition Sheets* when children transitioned from one location to another and was the responsibility of the staff persons "assigned to the classroom."

Facility documentation showed that P1, P2, SP1, and SP2 each received training on the Reporting of Maltreatment of Minors Act and on the facility's policies, including the *Child Supervision and Face to Name Procedures* 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, state that "supervision" means 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; and that children are required to be supervised at all times.

Conclusion:

A. Maltreatment:

Information was consistent that on April 3, 2024, the AV was in the Toddler 1 classroom for approximately six minutes without the knowledge or supervision of SP1 and SP2 which was a violation of Minnesota Statutes, section 245A.02, subdivision 18, and Minnesota Rules, part 9503.0045, subpart 1, item A.

Although the AV was in a classroom designed for children who were the AV's age, the AV who was 18 months old, was unsupervised for approximately six minutes prior to being found by the CP so it was unlikely that the AV would be able to provide for him/herself in an emergency and staff persons were not aware that the AV was in the room in the event of any emergency. 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 could seriously endanger the AV's physical 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. 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 Reporting of Maltreatment of Minors Act and on the facility's procedures including the *Child Supervision and Face to Name Procedures.*

At the time of the incident, SP1 and SP2 were working in the Toddler 1 classroom and were each responsible for the care and supervision of all the children in the classroom, including the AV, and responsible for ensuring all the children were present after transition from the classroom to the playground. SP1 and SP2 were each 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 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 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 of the incident and determined that their policies and procedures were

adequate but not followed by SP1 and SP2. All employees were retrained on the facility's *Supervision Policy* and face to name procedure. SP1 and SP2 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.

On June 28, 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.