

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: 202404828

Date Issued: July 17, 2024

Name and Address of Facility Investigated:

Tutor Time of Lakeville
9475 176th Street West
Lakeville, MN 55044

Disposition: A nonmaltreatment mistake to an alleged victim by a staff person was not maltreatment.

License Number and Program Type:

1000997-CCC (Child Care Center)

Investigator(s):

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Suspected Maltreatment Reported:

It was reported that an alleged victim (AV) was left in a bathroom for three minutes without the supervision or knowledge of a staff person. The AV was unharmed.

Date of Incident(s): May 30, 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 June 21, 2024; from documentation at the facility; and through interviews conducted with the AV's family member (FM), facility staff persons (the SP, P1, and P2), and supervisory staff persons (P3 and P4).

At the time of the incident, the AV had just turned three years old and was enrolled in the facility's early preschool classroom.

The facility provided childcare services in a stand-alone building. There was a playground attached to the back. The pre-kindergarten (Pre-K) classroom opened onto the playground through an exterior door on the building. A student bathroom was inside the Pre-K classroom. When children on the playground needed to use a bathroom, staff typically brought them to the Pre-K bathroom because it was closest one.

The facility's *Incident Report Form* stated that on May 30, 2024, at 4:14 p.m., "[The AV] was in the bathroom in Pre-K for a short time unsupervised. [His/her] class was outside on the playground. Teacher found [the AV] in the bathroom and brought [him/her] back to the group. [S/he] was unharmed and not upset when asked if [s/he's] ok."

The FM said that the AV was unaware of the incident or that s/he had been unsupervised because s/he was using the bathroom and washing his/her hands at the time. The AV had a history of telling the FM everything that happened at the facility. "[S/he] didn't bring it up at all." "I don't think [s/he] noticed [s/he] was alone." The FM had no concerns with the facility's overall care and supervision.

P1 said that on the day of the incident, s/he was on the playground when s/he saw a child on the playground shaking the Pre-K exterior door handle, which alerted P1 that the door was unlocked. P1 went over to the door, looked inside to see if any children had managed to get inside, and saw the AV in the bathroom washing his/her hands. There was no one else in the room. The AV was "totally fine." P1 asked the AV how s/he got inside, and the AV said, "I don't know." P1 assumed the AV had let him/herself inside. Once the AV was back outside on the playground, P1 told P3.

P3 and P4 provided the following information:

- The facility had a camera system that showed the Pre-K playground door. P4 watched footage of the incident. However, the facility did not immediately download the footage and it was mistakenly recorded over and not available for this investigation.
- P4 determined the AV was unsupervised in the bathroom for three minutes. This was based on the video timestamp. The AV did not leave the bathroom during that time. There was no one else in the classroom with the AV.
- P4 said that the footage showed the following, which was also documented in the facility's *Internal Review*:

[The SP] held open an exterior door to let 2 kids [including the AV] into the PreK room to use the bathroom. There were multiple preschool classrooms out on the playground at the time. [The SP] let one child out of the building, and then followed - thus allowing the door to shut behind them. There was still [the AV] in the bathroom

and [s/he] was left unsupervised for 3 minutes.

- P4 identified the SP as being the one who let the AV into the Pre-K classroom and as being the one who returned to the playground without the AV. This identification was done by “honing in” on the staff person in the video and then comparing it to the staff who were on the playground at the time.
- P3 did not watch the video footage but spoke with P4 about it. P4 had zoomed in on the footage and described to P3 what the staff person who was holding the door and letting the AV inside looked like. According to P3, “[P2] is very tall, very slender. [S/he] was always wearing black jogger pants.” P3 said s/he looked back on the facility’s app pictures to identify who the staff person was who took the children to the bathroom. There was enough of a height difference between the SP and P2 and differences in their hair length, color, and style that P3 believed that P4 saw and described the SP as being the staff person in question.

The SP provided the following information:

- On May 30, 2024, the SP, P1, P2, and another staff person were on the playground with 30+ preschool and Pre-K children, who were intermittently being picked up by parents/guardians as the day was coming to an end.
- The SP said that s/he was not the one who let the AV into the Pre-K classroom and/or left the AV unsupervised and that P4 had misidentified staff in the video footage. P2 was actually the one responsible.
- According to the SP, P2 told him/her that s/he was bringing two children, including the AV, into the Pre-K classroom to use the bathroom. “And, then when [P2] came back out, all of a sudden, I asked, ‘Where is [the AV]?’” P2 responded, “Oh shoot,” and went back inside to get the AV. The SP did not recall when P2 returned with the AV. The SP believed the AV was unsupervised for about one to two minutes.
- The SP believed that s/he and P2 “looked alike.” They both had the same hair color and were dressed the same on that day.
- The SP said that s/he did not let the AV into the Pre-K classroom on that day to use the bathroom and was not the one who left the AV in the bathroom. The SP had let another child, not the AV, inside to use the bathroom but stayed with that child and did not leave him/her unsupervised.
- The SP said that s/he “never” left the children unsupervised when they used the bathroom. “I’ve never done something like that.”

P2 provided the following information:

- At the time of the incident, P2’s shift was over, and s/he was headed inside to prepare to leave for the day. P1 asked that P2 have an unrelated incident report signed by a supervisor and then return it to the playground before leaving. P2 agreed, went inside, and returned shortly after.
- Upon arriving back outside, P1 “interrogated” P2 about leaving the Pre-K door unlocked and asked if s/he

let any children inside. P2 said that s/he did not let any children inside, and believed the door was locked when s/he went inside and came back out at the time of the incident. P1 told P2 that the AV was discovered inside unsupervised. P2 asked if the AV was okay and said s/he did not let the AV inside.

- P2 said that s/he did not bring any children inside to the use the bathroom during the timeframe of the incident.

The facility's *Risk Reduction Plan* stated that children must be supervised and monitored when using the bathroom. The bathroom door must remain open with a staff person standing near/at the doorway. At no time should a child be left unattended or out of sight of a staff person.

Facility documentation stated that the SP, P1, P2, and P3 received training on the facility's *Risk Reduction Plan*, and the Reporting of Maltreatment of Minors Act. P4 was an administrative staff person, who did not work specifically at the facility or have direct contact with children at the facility. P4's training records were not reviewed as part of this investigation.

Relevant Minnesota Statutes and Rules:

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:

On May 30, 2024, the AV was left inside a classroom using the bathroom without the knowledge or supervision of a staff person for three minutes which was inconsistent with the facility's *Risk Reduction Plan* and in violation of Minnesota Statutes, section 245A.02, subdivision 18, and Minnesota Rules, part 9503.0045, subpart 1, item A. The AV was unharmed.

Although, the SP denied being the staff person responsible for the incident and said that it was P2, P4 identified the SP on the video footage and based on the description provided by P4 to P3 and P3's review of photos taken that day, P3 also believed the staff person in the video footage was the SP. P2 denied being responsible. Also, based on the SP's account, P2 went back inside to retrieve the AV after realizing what happened, but this was not consistent with P1's account that s/he went inside and discovered the AV. P1 then "interrogated" P2 when s/he came back outside with the signed incident report. P2 was not outside when the AV was discovered missing, which was inconsistent with the SP's account. Therefore, it was determined that the SP was the staff person observed in the video footage letting the AV inside and then leaving without the AV.

Minnesota Statutes, section 260E. 30, subdivision 3 states that rather than making a determination of substantiated maltreatment by an individual, the commissioner of human services shall determine that a nonmaltreatment mistake was made by the individual. A nonmaltreatment mistake occurs when:

- (1) at the time of the incident, the individual was performing duties identified in the center's child care program plan required under Minnesota Rules, part 9503.0045;
- (2) the individual has not been determined responsible for a similar incident that resulted in a finding of maltreatment for at least seven years;

- (3) the individual has not been determined to have committed a similar nonmaltreatment mistake under this paragraph for at least four years;
- (4) any injury to a child resulting from the incident, if treated, is treated only with remedies that are available over the counter, whether ordered by a medical professional or not; and
- (5) except for the period when the incident occurred, the facility and the individual providing services were both in compliance with all licensing requirements relevant to the incident.

Although the AV was unsupervised for three minutes while using the bathroom in the classroom, it was determined the SP's actions were a nonmaltreatment mistake for the following reasons:

- 1) At the time of the incident, the SP was performing duties identified in the center's childcare program plan. The SP was supervising children on the playground and let two children inside to use the bathroom but returned to the playground with only one child. The AV was in the classroom bathroom and did not seem aware that s/he was unsupervised and was using the bathroom and/or washing his/her hands for the duration of the incident;
- 2) The SP was not determined responsible for a similar incident of maltreatment within the previous seven years;
- 3) The SP was not determined responsible for a similar nonmaltreatment mistake under this paragraph within the previous four years;
- 4) The AV was uninjured and did not require medical care after the incident; and
- 5) Except for the period when the incident occurred, the facility and the SP were both in compliance with all licensing requirements relevant to the incident.

The nonmaltreatment mistake to the AV by the SP was not maltreatment.

Pursuant to Minnesota Statutes, section 260E.35, subdivision 6, paragraph (b), the investigative data in this report will be maintained by the Department of Human Services for a period of five years.

Action Taken by Facility:

The facility completed an internal review and determined that policies and procedures were adequate but not followed. The facility provided additional training to all staff on name to face counts and bathroom supervision; and also changed the playground schedule so fewer children were outside at a time.

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

The SP was not determined as a perpetrator of maltreatment of the AV because the Department of Human Services found that the incident for which the SP was responsible met the criteria to be determined a nonmaltreatment mistake. The SP was notified by the Office of Inspector General that any future incident of possible neglect of an alleged victim for which the SP is responsible might not be considered a nonmaltreatment mistake.

On July 17, 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.