

**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:** 202403212

**Date Issued:** July 24, 2024

**Name and Address of Facility Investigated:**

Stepping Stones Early Learning Center  
11253 Eagle View Boulevard  
Woodbury, MN 55129

**Disposition:** Maltreatment determined as to physical abuse of an alleged victim by a staff person and neglect of an alleged victim by three staff persons and the facility.

**License Number and Program Type:**

1095855-CCC (Child Care Center)

**Investigator(s):**

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**Suspected Maltreatment Reported:**

It was reported that an alleged victim (AV) sustained a fractured femur as a staff person (SP) changed his/her diaper. During the course of the investigation, it was alleged that the SP provided inaccurate information regarding how the AV sustained the injury and then multiple staff persons failed to notify the AV's family members about how the AV sustained the injury.

**Date of Incident(s):** April 11, 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 April 16, 2024; from documentation at the facility, law enforcement records, and medical records; and through eight interviews conducted with the AV's family members (FM1 and FM2), two facility supervisory staff person (P1 and P4), three facility staff persons (P2, P3, and the SP), and a medical doctor (MD) who was a child abuse pediatrician.

Facility documentation showed the AV was nine months old and enrolled in the Infant Blue classroom at the time of the incident.

The facility had four infant classrooms including the "Blue" classroom and the "Green" classroom which were next to each other. The Infant Blue classroom was a rectangle room with an open play area in the middle. Off to one side of the play area was a changing table. At the back of the changing table was a half wall and behind the changing table was a set of cubbies on a wall. Beyond the changing table was a sleeping room with cribs. 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 a video camera in the classroom that provided recorded footage. The facility used a mobile application (app) platform to communicate with families and streamline administrative functions.

FM1 and FM2 provided the following consistent information:

- On April 11, 2024, FM1 received a phone call from P1 who told him/her that s/he believed the AV fell while attempting to pull him/herself to "standing." P1 went on to say that the SP had changed the AV's diaper and set him/her down on the floor. Then, as the SP changed another child's diaper, s/he did not "visibly see" the AV but heard the AV "scream." The SP went to the AV and "observed" him/her "favoring" one leg while "army crawling" and not wanting to pull him/herself to stand. P1 and the SP "attempted" to ice the AV's leg but did not know where the AV was injured so they iced the leg in "general," and thought the AV should be "checked out."
- FM1 then called FM2 and relayed the information s/he had been told by P1. FM2 "immediately" went to the facility. FM2 stated that at approximately 3 p.m., a facility staff person met him/her at the facility door, walked him/her to the AV's classroom, and told FM2 that the AV was a "real mover" and had fallen and then "had not been" him/herself.
- When they arrived at the Infant Blue classroom, the SP told FM2 that s/he was at the changing table and did not have a "visual line" to the AV when the AV made "some noise." The SP "assumed" the AV fell. Then FM2 and the AV left the facility. FM2 stated that was all s/he "knew the first day."
- That evening at the AV's home, FM2 observed that the AV's right leg was "swollen" and s/he had a "red mark" in the joint area near his/her groin. The AV was also not him/herself so FM2 took the AV to the home of another family member, who was a nurse, for "another point of view." The family member looked at and "touched" the AV's leg. At that time, the family member "did not think" the AV's leg was

broken but they "should definitely" have the AV "checked out." FM2 took the AV home and put the AV to bed and the AV slept through the night.

- FM2 stated that on the morning of April 12, 2024, the AV's leg was "more swollen," and s/he had a "thumb like bruise" in the joint area between his/her hip and leg. FM1 made an appointment for the AV to be seen by a doctor. Then FM1 called the facility and told P4 that the AV would not be at the facility that day. At that time, P4 told him/her that the previous evening, P1 and P4 had completed an "incident report" with the SP. The SP "recalled" that as s/he changed the AV's diaper, s/he had "heard a pop" in the AV's leg. The SP told P1 and P4 that the AV did not cry and did not "seem upset" so the SP was not concerned and continued to change the AV's diaper and when it was complete, s/he set the AV on the floor. FM1 told P4 that no one mentioned that to him/her the previous day and asked P4 why no one had "disclosed" that information. P4 told FM1 that at the time of the initial phone call, P1 and P4 did not have that information and learned that later in the day.
- FM2 took the AV to their local medical clinic where the AV's leg was x-rayed and it was determined that the AV had sustained a "broken" right femur. The AV was referred to an emergency room and was taken there immediately by FM2.
- At approximately 11 a.m., FM2 and the AV arrived at the emergency room. A "splint" was applied to the AV's leg that evening and the next morning, around 8 a.m., the AV had a "procedure" to fix his/her leg. The AV then had a cast applied from his/her "chest to his/her right ankle and to the knee on the left side" and would need to wear it for at least four weeks.
- FM1 stated that prior to this incident, s/he did not have concerns with the facility.

Medical documents and the MD provided the following information:

- On April 12, 2024, at 9:15 a.m., at the clinic the AV was diagnosed with a "fracture of the right femoral diaphysis" (right thigh bone shaft), and the "nonaccidental trauma" regarding how the AV sustained the injury was a "concern" given the AV's age and the "location/type" of injury. The AV was referred to the emergency room and FM2 transported the AV there.
- On April 12, 2024, the AV was seen at the emergency department of the hospital where a splint was applied to the AV's right leg. The AV was admitted to "trauma" services, given intravenous (IV) fluids, and an acetaminophen injection.
- The AV had one "small bruise" about the size of a "pencil eraser" that was "slightly raised" on his/her "lower right abdomen" and two "small bruises" on his/her "right thigh."
- The MD documented that a "femur fracture is very unusual in a child this age. Additionally, the fall was reportedly unwitnessed, and it is possible that [the AV] never had a fall. It is highly concerning that a pop was heard or felt during the diaper change immediately preceding [his/her] symptoms. The fracture could be the result of forceful manipulation during a diaper change but would in no way be expected during routine care." In addition, "3 (three) small bruises that would not be expected from routine care nor would they be expected from a routine fall."
- The MD stated that the bruising on the AV's thigh and abdomen were not "expected from routine care"

or caused by a "routine fall." A femoral fracture in a nine-month-old child was "unusual" and not something that would occur during "routine diaper changing activities" and breaking the AV's femur would take "excessive force." That the SP heard a pop while changing the AV's diaper was "highly concerning" because often when people talk about breaking bones, they talk about "hearing a pop." Due to the AV's "limited mobility, significant fracture and bruises in two different locations," the MD had a concern for "inflicted trauma," including that the fracture "could be the result of forceful manipulation during a diaper change."

- On April 12, 2024, the AV had a "skeletal survey" which showed that the AV's "bone mineral density" "appeared normal" and the AV had "no evidence of metabolic bone disease or skeletal dysplasia." In addition, there was "no family history of frequent fractures."
- The AV was not diagnosed with "easy bruising or bleeding," did not have anemia, and did not have bleeding disorders.
- On April 13, 2024, the AV had a "closed reduction" of the right femur fracture and a "spica cast" was applied to the AV's right leg and body under "general anesthesia." (Orthoinfo.aaos.org defined a closed reduction as the broken bone being manipulated back into place without an operation. In addition, a spica cast was a "cast that begins at the chest and extends all the way down the fractured leg. The cast may also extend down the uninjured leg or stop at the knee or hip.")
- Later that day, the AV was prescribed acetaminophen, ibuprofen, and oxycodone as needed for pain and discharged. In addition, future physical therapy for "asymmetric strength" after the AV has the cast removed was recommended.

The SP provided the following information to this investigator and the LEO:

- On April 11, 2024, the SP worked in the Infant Blue room alone with four children including the AV. Before the AV went down for nap, s/he was not "fussy." At approximately 3 p.m., the AV woke up "fussy" because s/he had a bowel movement in his/her diaper. The SP got the AV out of his/her crib and started changing his/her diaper. The AV calmed and was a "little whiny."
- The room was "dark," the AV was "squirming a lot" and had fecal matter "all the way up" his/her back. The SP said s/he was not "angry" with the AV and "lifted" the AV's "legs up" with his/her left hand at the AV's ankles. The SP did not "know what happened" but s/he "maybe" applied "a little too much pressure" as s/he pushed the AV's right leg back because "out of the blue" the SP "heard a crack." The AV cried "like a pain cry" and "screamed a little more." The SP felt the AV's right leg but did not "know where the cracking came from." The SP stated s/he could not recall how much pressure s/he used when s/he pushed the AV's leg back.
- The SP got "scared" and finished changing the AV's diaper, removed him/her from the changing table, and lay him/her down on the floor so s/he could wash his/her hands. During this, the AV cried.
- The SP then went to the Infant Green classroom door and asked P2 to come into the Infant Blue classroom. When P2 did so, the SP took the AV and "ran" to P1 and told him/her what "happened." The SP said s/he told P1 that the AV fell which at the time the SP knew was not true. The SP carried the AV back to the infant blue classroom and P1 followed. Then SP and P1 looked at the AV's right leg and

applied an ice pack to it.

- FM1 was notified “right away” that the AV hurt his/her leg. The SP stated s/he could not recall when FM2 picked up the AV if FM2 was told that s/he heard “a crack” as s/he changed the AV’s diaper.
- The SP completed an incident report writing that the AV fell. The SP said s/he told P1 a “lie” because s/he was “worried” and “caught off guard.” The SP said that “shortly afterwards,” after FM2 and the AV had left the facility, the SP talked to P1 and P4 and told them that while s/he was changing the AV’s diaper, s/he heard “a crack.” The SP was not sure if the incident report was changed to show the AV’s injuries occurred on the changing table.
- The SP stated s/he “should have lifted up” the AV’s legs more and instead s/he “pushed back more,” “put too much pressure backwards,” and “pushed too down” on the AV’s right leg and thought that was “what happened” and “it was a big accident.” Initially, the SP stated that s/he “heard the crack” and then later stated that s/he did not hear the crack but “felt the crack” in the AV’s leg. The SP did not know how the AV sustained bruises on his/her right leg and “maybe” the bruising occurred when s/he moved the AV’s leg.
- The SP said the facility “really did not train” the SP on how to lift a child’s legs while changing a diaper and s/he knew how because s/he had been “changing diapers” since s/he was “eight years old.” The facility had a diaper changing procedure policy that included instructions on how often to change diapers and how to clean up after a diaper change.

P1, P4, and facility documentation provided the following consistent information:

- On April 11, 2024, at approximately 3 p.m., P1 was in a classroom when the SP brought the AV to him/her and “seemed panicky.” The SP told P1 that “something was wrong” with the AV’s leg and that the AV was not “putting pressure” on his/her right leg. P1 and the SP walked to the Infant Blue classroom and P1 asked the SP to “walk through” what had happened. The SP told P1 that while s/he changed another child’s diaper, the AV “pulled” him/herself up, “fell,” and “hurt” his/her leg.
- P1 “looked at” the AV’s leg for “swelling,” “moved” the AV’s “thigh,” and “checked” the AV’s “knee.” The AV seemed “uncomfortable” but did not “wail in pain.” P1 did not see any swelling or bruising on the AV’s leg. P1 got an ice pack and had the SP put it on the AV’s right leg. Then P1 called FM1 and told him/her that the AV fell and was “favoring” his/her right leg. FM1 told P1 that FM2 would pick up the AV. FM2 arrived at the facility between 3:30 and 3:45 p.m., and left with the AV.
- An incident report was written by the SP that stated the AV “slipped” as s/he tried to pull him/herself up and there was “some leg sensitivity present.” An “ice pack and TLC” were administered to the AV. P1 went back to work in a classroom. Shortly after, P1 “poked” his/her head out of the classroom door and told P2 that s/he sent the AV home because “something happened” to his/her leg and s/he was “not putting weight on it.” P2 told P1 that they would have to look at the video to determine what had happened.
- Between 4 and 4:50 p.m., P1 “brainstormed” with the SP and P2 about “anything else” that may have happened to the AV. P4 stated the SP then told him/her and P1 that s/he had not been “fully truthful” and that as s/he changed the AV’s diaper, s/he “heard a pop” in the AV’s leg. P1 and P2 thanked the SP

for being truthful and told the SP that they would look at video footage for the day.

- At 4:50 p.m., via the app, the SP wrote a message to FM1 checking in to see how the AV was doing. At 7:50 p.m., FM1 wrote back that the AV was given ibuprofen and was doing "ok." At 7:55 p.m., P4 wrote back, "Good to hear! We appreciate the update." Neither P1 nor P4 told FM1 or FM2 what the SP said about hearing/feeling a pop from the AV's leg while changing the AV's diaper. P4 stated that because FM1 stated the AV was "ok," s/he did not "think it was relevant" to tell FM1 what the SP said. P1 twice stated s/he did not "know" why s/he did not tell FM1 or FM2 what the SP said.
- On April 12, 2024, at approximately 7:05 a.m., FM1 called the facility and talked with P4 and told him/her that FM2 was going to take the AV to be seen by a medical professional. P4 told FM1 that the SP had "simultaneously" heard and felt the AV's leg make a "popping sound" as s/he changed the AV's diaper. FM1 stated that s/he was not told this the previous day and P4 told FM1 that it was "new information" that s/he learned after the phone call to FM1 regarding the injury.
- On April 16, 2024, P1 reviewed the video footage from April 11, 2024. P1 said s/he saw the SP change the AV's diaper after nap time and the SP was "very gentle." The SP held the AV "up" to see "about [his/her] leg." In the video, P1 did not see the AV fall.

P2 stated that on April 11, 2024, at the "middle of the day," the SP came into the Infant Green room. The SP asked if either P2 or P3 could step into the Infant Blue classroom because s/he thought the AV had "broke" his/her leg and s/he needed to talk with P1. P2 did not ask the SP questions because s/he figured the SP "needed to go quickly." P2 and the SP then left the Infant Green classroom and went into the Infant Blue classroom where the SP picked up the AV and left the room. A few minutes later, the SP, the AV, and P1 returned. P1 "looked at" and "softly touched" the AV's right leg. The AV did not cry and let P1 hold him/her and look at his/her leg. Then P2 left the room and went back to the Infant Green classroom.

P3 stated that on April 11, 2023, between 2:30 and 3 p.m., the SP "knocked" on the Infant Green classroom door and asked if either P2 or P3 could step in for him/her. The SP told them s/he needed to find P1 because s/he believe the AV had broken his/her leg. The SP waited "seconds" and then P2 "quickly popped up" and left the Infant Green room. P3 remained with the children in the Infant Green classroom.

The facility provided video footage of the incident on April 11, 2024, which was time stamped but did not have audio. The video was black and white, the lights appeared to be partially off, and the window curtains were closed. The crib area and the changing table areas were dark and were only partially in view of the camera. The video showed the following:

- At 2:54 p.m., the SP walked to the crib area and bent over the AV's crib for approximately 20 seconds. Then the SP picked up the AV and carried him/her toward the play area. The AV faced the SP who had his/her left hand around the AV's back and his/her right hand under the AV's buttocks.
- At 2:54:37 p.m., the SP bent down, turned the AV outward, and released the AV a couple of inches above the floor. The AV landed on his/her buttocks in a seated position. Four seconds later, the SP picked up the AV and sat in a chair with the AV in his/her lap. The AV appeared to be crying.
- At 2:55:05 p.m., the SP stood up and held the AV outward with his/her left arm around the AV's waist. The AV kicked both of his/her legs. Then the SP walked to the changing table and lay the AV on the table. The AV's head was to the left side of the SP. (Because of the half-wall, neither the AV nor the

- SP's hands were visible during the diaper change.)
- At 2:58:07 p.m., the SP lifted the AV to a standing position on the changing table, supported the AV under his/her arms, and held him/her there for five seconds. The AV stood and then his/her legs bent, and the SP lifted and held the AV.
  - At 2:58:20 p.m., the SP lay the AV back on the changing table, turned so his/her back was to the AV, and walked two steps to the cubbies behind the changing table. (This was a violation of the facility's *Diapering Procedure*, which stated that a staff person must keep at least one hand on a child at all times while changing a diaper and a violation of Minnesota Rules, part 9503.0140, subpart, 12, which states in part that the center must follow diaper changing procedures.) Then the SP turned and walked back to the changing table with a diaper in his/her hand.
  - At 2:59:33 p.m., the SP lifted the AV to a standing position on the changing table, supported the AV under his/her arms, held him/her there for two seconds, and pulled up the AV's shorts. Then the SP held the AV in a standing position for another three seconds before s/he lifted the AV off the changing table and carried him/her to the play area. The SP's left arm was on the AV's back, his/her right arm was under the AV's buttocks, and right hand was on the back of the AV's right thigh.
  - At 2:59:51 p.m., the SP sat the AV on the floor on his/her buttocks in a seated position. The SP walked back to the diaper changing table, picked up the AV's soiled diaper and threw it in the trash. (The SP did not wash the AV's hands or his/her hands or the AV's hands after the diaper change. This was a violation of the facility's health policies and *Diapering Procedure* and a violation of Minnesota Rules 9503.0140, subpart 13 and 14, which stated that a child's hands and a staff person's hands must be washed with soap and water after a diaper change.) Most of the AV's body was off camera and a portion of the AV could be partially seen.
  - At 3:00:13 p.m., the SP walked back to the AV, bent down, and picked the AV up with both hands around his/her waist and sat him/her back down on his/her buttocks. The SP then stood upright, turned, and walked to the crib area and lifted another child out of his/her crib. The SP carried that child to the play area and sat him/her down on his/her buttocks on the floor near the AV. Then the SP picked up and used a tablet.
  - At 3:01:07 p.m., the SP squatted down near the AV and the other child. The view of the SP's hands was obstructed. The SP then moved in and out of camera view.
  - At 3:01:34 p.m., the SP stood up and walked toward the classroom door out of camera view.
  - At 3:01:50 p.m., the SP walked back from the classroom door into camera view and then walked out of view.
  - At 3:03:24 p.m., the SP walked back into camera view and walked toward the classroom door and out of camera view.
  - At 3:03:51 p.m., the SP walked back from the classroom door into camera view. The SP picked up the AV as P2 walked into camera view. The SP walked toward the classroom door and out of camera view carrying the AV. The video ended.

Law enforcement records showed that this report was submitted to the county attorney for charges of possible malicious punishment of a child.

The facility's First Aid book published in 2012 by Emergency Care and Safety Institute, showed that "it may be difficult to tell if a bone" was broken, but "a good indication of a possible broken bone" would be if a "victim

heard or felt the bone snap." To care for a bone injury, the injured part should be "stabilized" to "prevent movement. "Call 9-1-1" for any "large bone fractures (such as the thigh)."

The facility's *Parent Handbook* provided the following information:

- “If any injury or accident occurs, the nearest staff person will assist the child. If the injury may need medical attention, we will contact the parent or the emergency contact person designated by the parent.”
- “Each child is provided with a positive model of acceptable behavior.”
- “A child will never be subjected to any type of corporal punishment, which includes but is not limited to: rough handling, shoving, hair pulling, shaking, slapping, kicking, biting, pinching, hitting, shaking, etc.”

The facility’s *Emergency and Accident Policies and Records* showed that for a minor accident, “first aid would be administered, and the parents would be notified.” For a major accident that required immediate medical attention, “first aid would be administered and 9-1-1 would be called. After calling 9-1-1, the parents would be contacted immediately.”

The facility’s *Risk Reduction Plan and Diaper Changing Procedures* showed that while a child was on a changing table, staff persons kept “one hand” on the child “at all times.”

According to the American Academy of Orthopedic Surgeons, “The femur is the largest and strongest bone in the body. Because the femur is so strong, it usually takes a lot of force to break it. In a child, the femur can break as the result of a sudden forceful impact. The most common cause of thighbone fractures in infants under 1 year old is child abuse.”

Facility documentation showed that P1, P2, P3, P4, and the SP each received training on the Reporting of Maltreatment of Minors Act and on the facility’s policies, including the *Risk Reduction Plan, Emergency and Accident Policies and Records*, and *Diapering Procedures* and the facility’s *Parent Handbook* and American Heart Association first aid prior to the incident.

*Relevant Rules and/or Statutes:*

Minnesota Rules, part 9503.0055, subpart 3, item A, states that the license holder must have and enforce a policy that prohibits the following actions by or at the direction of a staff persons: Subjection of a child to corporal punishment, which includes, but is not limited to, rough handling, shoving, hair pulling, ear pulling, shaking, slapping, kicking, biting, pinching, hitting, and spanking.

**Conclusion:**

A. Maltreatment:

Regarding the Incident:

Consistent information was provided that on April 11, 2024, the AV was in the Infant Blue classroom with the SP when the AV’s right leg was fractured. The SP stated s/he “pushed” the AV’s legs back and applied “pressure” and should have “lifted” more instead of pushing the AV’s legs as s/he changed his/her diaper. The SP said s/he “felt” and “heard” a “crack” or a “pop” from the AV’s right leg. The AV sustained a fractured femur in addition to bruises on his/her inner right thigh and abdomen.

The SP’s action of applying enough pressure to cause bruising and an injury to the AV’s was inconsistent with the

standards of a professional caregiver in a facility licensed by the Minnesota Department of Human Services; a violation of the facility's behavior guidance policy; and a violation of Minnesota Rules, part 9503.0055, subpart 3, item A.

According to the American Academy of Orthopedic Surgeons, "The femur is the largest and strongest bone in the body. Because the femur is so strong, it usually takes a lot of force to break it. In a child, the femur can break as the result of a sudden forceful impact. The most common cause of thighbone fractures in infants under 1 year old is child abuse." Given that the SP felt and heard a crack in the AV's leg as s/he applied pressure when pushing the AV's legs back to change the AV's diaper, the amount of pressure applied to the AV's legs was not accidental. In addition, according to the MD, the bruising and fractured femur the AV sustained were "unusual" and not something that would occur during "routine care" and that "could be the result of forceful manipulation during a diaper change;" and that the AV had medical testing completed and did not have a "metabolic bone disease, skeletal dysplasia, anemia, or bruising disorders," there was a preponderance of the evidence that the SP's actions were not accidental and caused injury to the AV.

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.)

Regarding the Care after the Incident:

On April 11, 2024, between 2:20 and 3 p.m., the SP came into a classroom and told P2 and P3 that s/he thought the AV had broken his/her leg. Shortly after, when P1 came into the room, the SP told P1 that the AV fell and hurt his/her leg. Between 4 and 4:50 p.m., the SP told P1 and P4 that when s/he was changing the AV's diaper s/he had heard and felt a pop from the AV's leg. At 4:50 p.m., the SP communicated with FM1 via the app asking how the AV was doing and at 7:50 p.m. FM1 responded "ok." At 7:55 p.m., P4 replied to FM1 "Good to hear! We appreciate the update." At no point did the SP, P1, or P4 tell FM1 that the SP had heard and felt a crack in the AV's right leg. P4 stated that because FM1 stated the AV was "ok," s/he did not "think it was relevant" and P1 twice stated s/he did not "know" why s/he did not tell FM1 what the SP said.

FM2 stated that on April 12, 2024, in the morning, the AV's leg was "more swollen," and that the AV had a "thumb like bruise" in the joint area between his/her hip and leg. When FM1 called the facility and told P4 that the AV was going to be seen by a doctor, P4 then told FM1 that the SP said s/he had heard a pop in the AV's leg as s/he changed his/her diaper the previous day and that the AV did not cry and did not "seem upset" so the SP was not concerned and continued to change the AV's diaper and when it was complete, s/he set the AV on the floor.

Although P1, P4, and the SP administered first aid via an ice pack to the AV's leg, the first aid training stated that a "a good indication of a possible broken bone" would be if a "victim heard or felt the bone snap" and that to care for a bone injury, the injured part should be "stabilized" to "prevent movement. "Call 9-1-1" for any "large bone fractures (such as the thigh)."

Although FM2 stated that a family member, who was a nurse, looked at the AV, s/he was not in a position to diagnose the AV's leg and did not have accurate information regarding how the AV sustained the injury. The SP initially provided inaccurate information regarding how the AV sustained his/her injury then within one hour of the incident, the SP told P1 and P4 about hearing/feeling a crack/pop during diaper change, yet no one provided that information to FM1 or FM2 until the next morning when FM1 called the facility, over 18 hours later, telling

them that they were taking the AV to the doctor. This delay resulted in the AV not receiving professional medical care for over 18 hours. Therefore, there was a preponderance of the evidence that there was a failure to provide the AV with necessary care required 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 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.

P1, P4, and the SP each received training on the Reporting of Maltreatment of Minors Act and on the facility's policies, including the *Risk Reduction Plan, Emergency and Accident Policies and Records, and Diapering Procedures* and the facility's *Parent Handbook* and American Heart Association first aid prior to the incident.

Regarding the Incident:

The SP was responsible for the care and supervision of the AV at the time of the incident.

The SP was responsible for maltreatment of the AV.

Regarding the Care after the Incident:

The SP initially provided inaccurate information to P1 and P4 regarding how the AV sustained the injury and failed to notify FM1 and FM2 about hearing the pop/crack. The SP was responsible for the maltreatment of the AV.

P1 and P4 had significant administrative and supervisory authority over the operation of the facility and maintaining compliance with Rules and Statutes. Although the SP initially provide them inaccurate information regarding how the AV sustained the injury, within the hour the SP provided them accurate information and neither P1 nor P4 notified FM1 or FM2 that the SP had provided false information that the AV had fallen and had in fact heard/felt a pop/crack in the AV's leg as s/he changed his/her diaper. Therefore, P1, P4, and the facility 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. The Office of Inspector General is also required to evaluate whether substantiated maltreatment by a facility meets the statutory criteria to be determined as "serious."

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.

Regarding the Incident:

It was determined that the substantiated physical abuse for which the SP was responsible was not "recurring" because this was a single incident.

However, it was "serious" maltreatment because the AV sustained a serious injury bruising and fractured femur and required the care of a physician including a closed reduction of the femur under general anesthesia and

narcotic pain relievers.

Regarding the Care after the Incident:

It was determined that the substantiated neglect for which the SP, P1, and P4, and the facility were responsible was not serious maltreatment because the AV's broken femur that required the care of a physician was not a result of the delay in medical care.

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 their policies and procedures were followed. The facility provided additional training and reminders to all staff persons on how to properly change a diaper. The SP no longer worked at the facility.

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

The SP was notified that s/he was responsible for serious maltreatment and that any future background studies for facilities, 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, will result in his/her disqualification. The determination that the SP was responsible for maltreatment is subject to appeal.

P1 and P4 were not disqualified from providing direct care services as a result of the maltreatment determination in this report. However, P1 and P4 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 P1 and P4 were each responsible for maltreatment is subject to appeal.

On July 24, 2024, the license holder was ordered to forfeit a fine of \$1000 as a result of the substantiated maltreatment for which the facility was responsible. The maltreatment determination and the Order to Forfeit a Fine are each subject to appeal.

On July 24, 2024, the facility was issued a Correction Order for the violations 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.