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: 202403249

Date Issued: July 26, 2024

Name and Address of Facility Investigated:

Hastings Child Development Center LLC
210 17th Street W
Hastings, MN 55033

Disposition: Maltreatment determined as to neglect of an alleged victim by three staff persons and the facility.

License Number and Program Type:

1053682-CCC (Child Care Center)

Investigator(s):

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Suspected Maltreatment Reported:

It was reported that a staff person (SP) stepped over a bookshelf and rolled his/her ankle while carrying an alleged victim (AV). The SP and the AV fell to the floor and the AV sustained a fracture to his/her right femur.

Date of Incident(s): March 13, 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 May 9, 2024; from documentation at the facility and medical records; and through five interviews conducted with a supervisory staff person (P1), three facility staff persons (SP, P2, P3), and the AV's family member (FM1).

This investigator scheduled a telephone interview with another staff person (P4) but P4 did not answer his/her telephone at the designated time. P4 called back and left a message stating that s/he would be available until a specified time. This investigator called back a minute after P4 left the voicemail, and again P4 did not answer the telephone.

The facility was a stand-alone building servicing infants through school aged children. The Fireflies Two (infant) classroom had an eating area with hard surface flooring that had two kidney shaped tables with highchairs built into the tables, a counter for food prep, and a changing table. The rest of the classroom was carpeted and had separate areas for cribs and for play. The play area was separated from the crib and eating areas by shelves and a recliner. There was a soft infant climber in the play area. At the time of the incident, there was a bookshelf placed between the shelves and the recliner to prevent the infants from crawling from the play area to the crib or eating areas. The bookshelf was approximately 30 inches wide, 14 inches high, and 15 inches deep.

The AV's *Medical Records* stated the AV arrived at an emergency department on March 13, 2024, at 1:16 p.m. after a facility staff person who was carrying the AV rolled his/her ankle and fell down with the AV. FM1 stated the AV was "fussy" with moving the extremities on his/her right side since the fall. The AV presented with tenderness and limited range of motion in his/her right hip and knee, no other lower extremity tenderness, and full range of motion in his/her upper extremities. There were no signs of other trauma or bruising. The AV was diagnosed with a right femur fracture, and a temporary plaster splint was applied for pain control and stabilization for the AV to be transferred to a specialty hospital via ambulance later that day. On March 14, 2024, at 10 a.m., the AV was medicated with morphine for a mold fitting of a spica (body) brace and the fitted brace was applied at 2:45 p.m. the same day after another dose of morphine. The AV was discharged later on March 14, 2024.

According to www.orthoinfo.aaos.org, a spica cast 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.

On March 13, 2024, a log of the facility's Brightwheel App (an application used to communicate with family members) showed the below:

- At 8:08 a.m. the AV was checked into the facility by FM1.
- At 8:33 a.m. the AV ate "some" breakfast.
- At 9:10 a.m. the AV had a diaper change. (This entry was logged after the incident occurred.)
- At 9:23 a.m. the AV started a nap.
- At 10:13 a.m. the AV woke up from nap.
- At 10:18 a.m. the AV received a bottle (0 ounces were consumed).
- At 10:22 a.m. the AV had a temperature of 99.5 degrees Fahrenheit.
- At 10:46 a.m. the AV started a nap. A photo was uploaded at 10:47 a.m. showing a thermometer reading of 100.0 degrees Fahrenheit.
- At 11:52 a.m. the AV was checked out of the facility by FM1

The facility's *Illness Report Form* stated that on March 13, 2024, at 10:43 a.m., the AV had a fever and unexplained lethargy, and the form was signed by FM1 at 11:57 a.m.

The facility's *Accident/Incident Report Form* stated that on March 13, 2024, at 9 a.m., a [staff person] was carrying the AV when the [staff person] stepped wrong and rolled [his/her] ankle causing [him/her] to fall with the AV. The [staff person] tried to brace [him/herself] from the fall with [his/her] arm/side. The facility documented, "We checked [the AV] all over, we were concerned about [his/her] arms, but they looked alright. We moved all limbs, we snuggled and cared for [him/her]. We called [FM1] right away." This form was not given to FM1 at pick up, so it was not signed.

FM1 provided the following information:

- The AV started attending the facility on Monday March 4, 2024. The AV developed an ear infection on the evening of March 7, and was absent for several days. Wednesday, March 13, 2024, (the day of the incident) was the AV's first day back to the facility.

- On Wednesday, March 13, the AV woke up fever free, but s/he was still not eating or drinking much. FM1 dropped the AV off at the facility a little after 8 a.m., and around 9:25 a.m., FM1 received a telephone call from the SP stating that s/he was holding the AV when s/he rolled his/her ankle and fell while carrying the AV. The SP told FM1 that s/he caught him/herself with his/her arm/side. The SP told FM1, "We checked [the AV] out, calmed [the AV] down, [the AV] seemed 'okay,' and [the AV] did not hit his/her head." The SP said if "anything hurt" it would have been the AV's right arm. The SP told FM1 there was "no urgency" to come and get the AV. FM1 said s/he trusted the facility that the AV was "not that bad" based on the call s/he received.

- Around 11 a.m., FM1 received another telephone call that the AV had a fever and needed to go home. FM1 thought it was "weird" because the AV was doing "much better," was in "good spirits," and had not had a fever in the morning. Around 11:50 a.m., FM1 arrived at the facility and spoke with P1 who mentioned that a lot of children were not responding to the first round of antibiotics for an illness that was going around, and FM1 thought that must be what was going on with the AV. P1 did mention the fall and that the SP had gone home already for the day.

- When FM1 walked into the classroom, the AV was in his/her crib and the rest of the children were at the table eating. When P2 lifted the AV from the crib, the AV cried "really hard." When P2 walked over to FM1 with the AV in P2's arms, the AV's hands were "shaking" and FM1 thought the AV was having "a febrile (fever) seizure." When FM1 took the AV, the AV clung to FM1 and tucked his/her head into FM1's neck and did not move. At this time FM1 still thought the AV's behavior was related to an ear infection, as the facility made the fall seem like a "minor" situation and that the AV was "fine." When FM1 moved the AV away from him/her the AV cried. FM1 told this investigator that typically the AV did not cry hard when s/he was sick but became "snuggly."

- FM1 buckled the AV in his/her car seat and the AV was quiet on the way home. When FM1 got the AV home, the AV started crying so FM1 tried calling the AV's doctor while another family member (FM2) held the AV. Whenever FM2 moved "slightly" while holding the AV, the AV cried "really hard." FM1 gave the

AV ibuprofen because the AV was in apparent pain and was trying "super hard" not to move. The AV was "whimpering" and at that point, FM1 and FM2 thought the AV must be injured. They moved the AV's left arm, right arm, and left leg and the movements appeared to hurt the AV, but there was not a "strong reaction." When they got to the AV's right leg, they barely touched the AV, and the AV screamed. When looking at both the AV's legs, they could tell the right leg was swollen. FM1 sent a message through the Brightwheel App and then called P1 to let him/her know there was something wrong with the AV, FM1 and FM2 wanted to know more about what happened with the fall, and they were taking the AV to the emergency department. P1 did not really say much other than, "Sorry," and that s/he had been on the telephone trying to get more information from the SP. FM1 brought the AV to the emergency department, but left the AV buckled in his/her car seat until it was time for the exam because anytime the AV was moved s/he screamed.

- At the emergency department, FM1 learned that the AV's femur was "completely snapped right in half." At that time, P1 messaged FM1 and FM1 told P1 what was wrong with the AV and sent P1 screen shots of the x-rays. P1 stated that the staff persons in the infant room forgot to have FM1 sign the report for the fall (FM1 stated they had him/her sign the report for the fever, but FM1 was not presented a report to sign for the fall when s/he picked up). The AV was transferred to a specialty hospital and did not receive anything other than ibuprofen to relieve pain until 11 p.m. that evening because s/he was dehydrated from being sick over the weekend. When an IV was finally placed around 10 or 11 p.m. that evening the AV received morphine and valium because s/he had been having muscle spasms which was the "most painful" part for the AV.

- On March 14, 2024, the AV was placed in a spica brace (different from a spica cast because the top cover could be taken off to give the AV a sponge bath or change his/her diaper, but the healing process was the same). FM1 was told by the emergency department doctors that this was the most painful type of break a human could have. The AV was discharged later that evening.

- Also on March 14, 2024, while the AV was still in the hospital, FM1 called P1 to discuss the incident. FM1 told this investigator that s/he trusted the accident happened the way the facility described it to him/her, but s/he was also confused how no one at the facility noticed the AV was injured for two to three hours after the fall, given that after the fall, any time the AV was set down, the AV screamed right away. If staff persons changed the AV's diaper or gave the AV a bottle after the fall, "How did they not put two and two together?" FM1 again was told the SP went home, and FM1 wondered if the fall was so bad the SP went home for the day, why was the AV not also sent home right after the fall.

The SP provided the following information:

- On an unknown date in March, after the AV had been out sick, the AV returned to the facility and still seemed "lethargic." Prior to the incident, the AV crawled around one or two crawls and then sat up, "played a little," observed, and then crawled one or two crawls again, and sat up again.

- The AV did not eat much at breakfast, so the SP removed the AV from the highchair and changed his/her diaper. After the AV's diaper was changed, the SP began to carry the AV over to the play area. The SP stated the AV was slightly to the SP's left side, but still in front of the SP facing toward the SP. The SP stepped over the bookshelf, and s/he "slipped" on a toy and fell. (Note: this conflicted with a written statement the SP prepared for P1 in which the SP documented that s/he stepped around the bookshelf).

- The SP stated that s/he did not think the AV hit his/her head during the fall, because the SP was holding the AV's head in his/her hand and felt the AV's head the whole time. However, immediately after the fall s/he still looked over the AV's head and checked his/her eyes for pupil dilation, as the SP was trained to do, and the AV's pupils "seemed normal and reactive." The AV was "crying and fussy" but not "crazy miserable" so P2 came over to check on the AV and the SP and then called P1. The SP thought the AV might have hit his/her shoulder, so the SP checked the AV's arm and thought s/he moved the AV's shoulder and felt the AV's head. The SP scanned over the rest of the AV's body and did not see anything and five to ten minutes after the fall, the AV started to fall asleep.

- The SP called FM1 "about 10 to 15 minutes" after the fall while P2 was laying the AV down for a nap in his/her crib. The SP told FM1 that a staff person had fallen with the AV, and the AV was a little upset after the fall, but "seemed to be okay." The AV seemed tired, and the staff persons were putting the AV down for a nap. The SP told FM1 that staff persons would let FM1 know if anything changed.

- The AV woke up and needed a bottle, but the AV did not seem to want it. The AV was "a little bit upset" and still seemed "tired." FM1 had told the staff persons that the AV had been "fussy" with his/her bottle since the AV had been sick. The SP thought s/he had tried to set the AV down at some point to see if the AV wanted to play, but the AV still seemed "tired" and was "whining," so the AV was laid back down. The SP thought P3 changed the AV's diaper either when the AV woke up or before the AV was laid back down, and the SP stated that they made a "mental note" that the AV was "not acting like [him/herself]."

- While the AV was awake, s/he developed a fever. FM1 was called to pick the AV up about an hour and a half to two hours after the fall. The SP left while the AV was asleep and heard FM1 picked up the AV about ten minutes after the SP left.

- The SP's first aid training for an injury was to "visually check" and if there was anything "concerning" go from there, move the limbs around, and treat the area. If pupil dilation was within normal limits, the SP was trained to keep an eye on the injured person for changes in behavior or actions. The SP stated that s/he moved one of the AV's arms, but the AV's legs and other arm were only moved to get the AV in and out of the crib, and not to specifically check for injury. The SP said P1 "kind of looked [the AV] over and felt [his/her] head." The SP did not feel the AV needed immediate care and did not feel there was a lack of care provided to the AV after the incident.

- The SP stated that the bookshelf had been placed between the shelves and recliner for no more than a month and was there to prevent the infants from crawling out of the toy area. The SP had witnessed other staff persons step over the bookshelf or go around it when they needed to move between the areas. The SP had previously stepped over the bookshelf as well. The SP did not recall if s/he had training on stepping over things but said that "common sense" would tell him/her not to. However, when the SP was in a "rush" to move around the classroom to help with other things, s/he stepped over the bookshelf out of "habit."

P2 provided the following information:

- On the day of the incident, P2 was at the sink getting washcloths after breakfast, P3 was at the tables with

the children, and the SP had changed the AV's diaper and began carrying the AV over to the play area. P2 heard P3 say, "Oh," and when P2 turned around the SP was on the floor with the AV.

- P2 went over to make sure both the AV and the SP were okay. P2 asked the SP if s/he thought the AV was "okay" and the SP thought maybe the AV's arm had been hurt, so P2 wiggled the AV's arm "real quick" while the SP held the AV and then P2 called P1 to the classroom.

- P2 went back and took the AV from the SP. The AV was crying and the fall "probably traumatized" the AV, but P2 said it did not "put up any red flags" because the AV moved "everything," the AV let P2 move "everything," and then the AV "calmed down." P2 described the AV's cry as "full loud," but nothing seemed to be bothering the AV as SP handed the AV to P2. P2 did not see the SP fall with the AV, but stated the SP told P2 that s/he rolled his/her ankle after stepping over the bookshelf.

- The SP told P2 that s/he supported the AV during the fall and his/her head did not hit the floor. P2 said the AV was tired and it was nap time, so the AV was placed in his/her crib. P2 said the SP called FM1 when everything "calmed down," within a half hour after the incident.

- P2 went on break around 10 a.m. and was told that while s/he was on break, the staff persons tried to give the AV a bottle, but the AV refused it. P2 was not sure if the AV received a diaper change while s/he was on break, but s/he did not change the AV's diaper after the incident.

- P2 did not speak with FM1 but stated FM1 was given the option of picking up the AV because the staff persons did not think anything "major" happened during the fall. FM1 was called to pick up the AV for a fever and arrived about an hour later to pick up the AV. The AV was asleep when FM1 walked in and when P2 picked the AV up out of his/her crib, the AV was sleepy and "startled" trying to wake up.

- P2 found out the next day the AV had a broken femur and that FM1 was keeping P1 up to date.

- P2 was trained to notify [management] and family members for a "minor" incident, and to call 9-1-1 for a "major" incident. P2 did not think the fall was a "major" incident because s/he moved the AV's limbs and "everything seemed fine," and when the AV was asleep, s/he was on his/her knees and stomach.

- P2 said that the bookshelf should not have been there and without it there, staff persons could have walked "normal," but stated that after the fall, s/he thought the facility did "everything by the book."

- P2 stated the bookshelf was in place between the shelves and recliner for about one to two months and was there to keep the infants in the carpeted area. P2 said staff persons slid the shelf out of the way with their hands when they needed to get past it. P2 said that "just that one time" a staff person stepped over the shelf, and that s/he personally would not have done with a child in his/her hand. (Note: when this investigator told P2 that video footage from the morning of the incident showed P2 and other staff persons stepping over the bookshelf multiple times, and P2 was asked why that was, P2 responded, "I don't know, I guess I just did," and that other staff persons could have but P2 "didn't really watch that.")

P1 provided the following information:

- On March 13, 2024, around 9 a.m., P2 "beeped" P1 to let him/her know about the fall. When P1 entered the infant classroom, s/he saw the SP on the floor and P2 was holding the AV. P1 was told that the SP fell while holding the AV.

- P1 asked if the AV was okay and the SP and P2 said they checked the AV over and s/he "seemed fine" and did not show any signs of injury. P1 said s/he touched the AV's arm, but it was only the AV's fifth day at the facility and the AV was "getting more upset" because the AV was not familiar with P1, so P1 stopped touching the AV. P1 asked if the AV hit his/her head, and the SP told P1 that s/he tucked and rolled the AV into the SP's body so s/he did not think the AV hit his/her head but the AV's right arm could have been injured. P2 said s/he had checked the AV, everything seemed "good" and there were no visible injuries on the AV's head. P1 told the SP and P2 to call FM1 to let him/her know what happened, and keep an eye on the AV. P1 left the classroom and when s/he came back in the AV was falling asleep. P1 stated that the AV had been out sick, and s/he was going to be taking a nap "relatively soon" anyway. P1 said the AV did not have a diaper change after the incident.

- P1 said the AV was sent home with a fever and about 30 minutes after FM1 left with the AV, FM1 sent a message on the Brightwheel App to talk to someone about the fall, because something seemed "off", and the AV seemed bothered by his/her right side. The SP left at 11:32 a.m. because there were extra staff persons, and the SP was "upset" and "felt bad" so P1 called the SP about FM1's concerns and the SP said that "the right arm" might be hurt. P1 texted FM1 later to see how the AV was and that was when FM1 stated that the AV had a broken leg.

- On the afternoon of March 13, 2024, P1 reminded the staff persons who were in the infant classroom about "never" stepping over equipment. The next morning, P1 had P2 move the bookshelf in order to remove the "temptation" to step over and not around it. P1 talked to the SP and P2 about how staff persons did not notice that the AV had a broken bone, and both the SP and P2 were caught "off guard" because they did not think the AV's behavior warranted concerns of a broken bone. FM1 was called and informed about the incident as per the facility policy, but P1 said "this might be" where we tell family members that staff persons recommend pick up in the future.

- P1 spoke with FM1 the next morning, and FM1 said the emergency doctors initially thought it was the AV's left leg not his/her right leg. FM1 told P1 that it was a "perfect storm" because the AV was new, and the staff persons did not know his/her typical behavior when s/he was sick.

- A third-party company came and pulled the video footage, so P1 did not see the incident until about a month after it happened and at that point s/he became aware that the SP stepped over the bookshelf. P1 stated that in the video s/he saw the SP clear the bookshelf and then the SP's back knee buckled, and s/he fell while holding the AV. P1 said the SP was holding the AV straight in front of him/her and the AV was facing outward. When they started to fall, the SP put out his/her right arm to brace him/herself. P1 then saw the SP comforting the AV, P2 come over to take the AV from the SP and walk over to "buzz" P1. P1 saw the SP feel the AV's head and arm while the SP was holding the AV. P1 did not see P2 check the AV's other limbs. P1 watched the video until the AV was placed in his/her crib for a nap.

- After P1 reviewed the video, P1 spoke with the SP about not stepping over things and the SP still stated that s/he rolled his/her ankle.

- P1 stated that the video time was off. (Note: on the day of the site visit the camera feed showed 11:04 a.m. when the actual time was 11:36 a.m.)

- P1 did not recall the how long the bookshelf had been placed between the shelves and the recliner. P1 thought "maybe" P2 put the bookshelf there to keep children from going over by the cribs. P1 said that the bookshelf slid and that staff persons just moved it out of the way when they needed to pass by it. P1 was not aware of staff persons walking over the bookshelf, and staff persons were trained to not walk over gates or enclosures while carrying children. P1 did not know if staff persons walked over the bookshelf when they were not carrying children and stated that s/he "probably had" but s/he did not typically work in that classroom.

- P1 stated that if a child had a severe injury, then 9-1-1 was called to have first responders assess the child and determine if they needed to be transported. P1 said the AV did not show "any signs of a major injury" after the fall, and that was why 9-1-1 was not called nor was FM1 told to pick the AV up. When staff persons felt a child might need non-emergency medical attention, they were to notify the family member right away. Because the SP fell with the AV, staff persons did call FM1 to tell him/her about the fall.

P3 provided the following information:

- At 10 a.m. on the day of the incident, when P3 went into the classroom to cover during staff breaks, the AV was asleep. P3 was informed that the SP fell earlier while carrying the AV. When the AV woke up, P3 changed his/her diaper. P3 said the AV seemed "fussy" but that the AV had just returned from being sick, so P3 thought maybe the AV was still not feeling well, or s/he was not quite awake from his/her nap. P3 did not notice anything "out of the ordinary" during the diaper change. (Note: no diaper change was documented in the Brightwheel app after the fall.)

- P3 heard that the SP was walking with the AV when the SP's foot got caught between two shelves and they fell. The SP twisted him/herself, so the AV did not hit his/her head but the AV ended up with a broken leg because of the fall.

- On other days, P3 said the AV was "happy" and only "fussed" when s/he was tired or hungry, but when set down, the AV went and played. On the day of the incident, the AV was "crying, whining" and wanting to be held by staff persons. P3 said the AV was set down, but then s/he was "upset" and crying and held his/her arms up like s/he wanted to be picked up.

- P3 said at no time did the AV's cry seem to indicate more than that the AV was tired or still not feeling well. P3 did not think the AV needed medical attention. P3 said the AV was awake for 30 to 45 minutes and then fell back asleep. During that time, the AV spiked a fever and s/he had to be picked up by FM1.

- P3 said s/he did not know why the bookshelf was placed between the shelves and the recliner, but that it was normally by a wall. If staff persons had to go past the bookshelf, they bent down and pushed it out of the way. P3 was trained to not step over any shelves, gates, or large toys. P3 had not witnessed other staff persons step over the bookshelf.

This investigator reviewed video footage from March 13, 2024, and noted the following:

- There was no audio on the video footage. At 7:38:06 a.m., FM1 dropped off the AV (Note: FM1 stated s/he dropped the AV off a little after 8 a.m., and the Brightwheel App showed the AV was checked in at 8:08 a.m. by FM1, so this time delay was consistent with what P1 stated about the video footage time being off approximately 32 minutes). P2 took the AV from FM1, and they talked for a few minutes. When FM1 left, the AV was smiling. P2 placed the AV on the carpeted toy area.

- The AV immediately began crawling around the toy area. The AV crawled several times around the room and while sometimes the AV went short distances (one to two crawl movements) and then sat up to play with toys, the AV also moved longer distances (11, 14, 17, and 24 crawl movements) including some rapid bursts of crawling motion. There were times the AV was on all fours and was rocking back and forth. There was one time the AV crawled over to a crawl though play structure and although the AV's top half of his/her body was not visible on the camera, the AV's bottom half (both legs) was seen in a standing position through the opening of the play structure. The AV then sat down and crawled away. The AV was then picked up by the SP and placed in a highchair for breakfast.

- The AV was faced away from the view of the camera for breakfast, so this investigator was not able to see him/her eating, but there appeared to be a full plate of food when the plate was moved at the end of breakfast. The AV dropped his/her sippy cup on the floor a few times and reached for it every time. The AV's legs were visible swinging under the table. After breakfast, the SP and removed the AV from the highchair, carried him/her over to the diaper changing table, and changed the AV's diaper.

- The SP picked up the AV after his/her diaper change and carried the AV in front of him/her slightly to SP's left side (the AV's low back was against the SP's chest) with the AV facing forward. The SP's left arm was around the AV's waist on the left side, and the SP's right arm was under the AV's bottom. P2 had his/her back turned at the counter, and P4 was cleaning up another child at a table.

- At 8:29 a.m. (adjusted time 9:01 a.m.), the SP (still carrying the AV) stepped his/her right foot down and it touched the front of the bookshelf. The SP then stepped over the bookshelf with his/her left foot. Due to another piece of equipment blocking the view of the back of the bookshelf it was not determined if the SP stepped on any object. However, it appeared that the SP's left foot landed firmly on the floor and then his/her back (right) foot caught on the bookshelf and then the SP's left knee buckled.

- The SP fell forward and put out his/her right arm to brace for the fall. The SP's left arm was still around the AV's waist and did not move. As they fell the AV was still facing forward (the SP was parallel to the floor as if in a plank position while the AV was perpendicular to the floor), so as they landed the AV's right leg took the impact of the SP falling on top of the AV and then the momentum of the fall carried them both forward and they landed on the floor with the SP on top of the AV. The SP rolled off of the AV, at which time the SP's left hand was still around the AV's waist, and the SP's right hand came off of the floor to the AV's right hip (having never braced the AV's head). The AV was in a child's pose position with his/her knees tucked up under him/her and his/her head had come to rest on a plastic ball.

- The SP laid on his/her left side and pulled the AV to him/her. The AV was crying when the SP moved the

AV into a seated position next to the SP. The SP's right hand was on the right side of the AV's head. The SP sat up slightly and moved his/her hand to the AV's forehead. P2 went over, crouched down next to the AV and the SP and put his/her arms under the AV's armpits. P2 then picked up the AV and carried him/her to a telephone in the classroom to call P1. As P2 carried the AV, P2 patted the AV's back or bottom.

- When P1 came in, P2 was kneeling with the AV and looked at and felt the AV's head. P1 spoke with the SP and then looked at the AV from a few feet away while P2 was still holding the AV. The AV had his/her head on P2's shoulder. P2 moved the AV's left arm, continued to hold the AV and sway back and forth while patting or rubbing the AV's back. P1 walked by P2 and the AV but P1 did not touch the AV. P2 handed the AV back to the SP who was seated on the floor. The SP held the AV close to him/her and swayed side to side while rubbing the AV's back. The AV's head was on the SP's shoulder. P1 left the classroom.

- The SP continued to sit on the floor while holding and rocking the AV while P2 and P4 cleaned up after breakfast and changed the other children's diapers. The AV appeared to be falling asleep. The SP handed the AV to P2 who then put the AV in his/her crib at 8:45 a.m. (adjusted time 9:17 a.m.) and P2 rubbed the AV's back for about a minute. Due to the location of the crib, the AV was not visible on camera. At 8:54 a.m. (adjusted time 9:26 a.m.) the SP called FM1. The AV was not removed from his/her crib for the remainder of the video which ended at 9:25 a.m. (adjusted time 9:57 a.m.). P2 and the SP did occasionally look into the crib to check on the AV.

- During the one hour and fifty-five minutes of the video clip, staff persons (including the SP, P1, P2, P4, and unidentified staff persons) stepped over the bookshelf 26 times while carrying a child, and 45 times while not carrying a child. There were four times that staff persons stepped over the bookshelf with a child in their arms in the presence of P1. (Note: there were multiple licensing violations observed in the video regarding diaper changing.)

The facility's *Injury and Illness Prevention Program* stated that the facility had established programs to train and re-train staff persons when appropriate, to assist them in avoiding dangerous or unhealthy conditions, and to remedy problems or hazards before they cause accidents or injuries. A staff person should report unsafe conditions immediately to his/her supervisor, if unable to remedy the situation him/herself.

The facility's *Emergency and Accident Policies-Emergencies* stated for "minor" accidents, first aid would be administered, and family members would be notified. For "major" accidents requiring immediate medical attention, first aid would be administered and 9-1-1 would be called. The facility's *Emergency and Accident Policies-Safety Rules* stated safety gates were to be used appropriately and "<u>are walked through and not over</u>" (emphasis in original).

The facility's *Parent Handbook* stated, "If your child would become injured while they are in care of [facility staff persons], our first step is to administer first aid. All staff [persons are] required to have current first aid training. If a wound is severe, we will make every effort to contact you (or designated emergency contact). Depending on the injury, we may contact your physician or 9-1-1 for immediate medical services."

Facility documentation showed that the SP, P1, P2, P3, and P4 were each trained on the facility's *Emergency and*

Accident Policies and the Reporting of Maltreatment of Minors Act. At the time of the incident, the SP, P1, and P2 each had current First-Aid/CPR training. P4 was still within his/her first 90 days of hire so s/he was not required to have competed First-Aid/CPR at that time. P4 received First-Aid/CPR training on March 21, 2024.

Conclusion:

A. Maltreatment:

Regarding the fall:

Consistent information was provided by FM1, the SP, P1, P2, P3, and video footage that on March 13, 2024, at 9:01 a.m., the SP began to carry the AV from the eating area to the play area. While carrying the AV, the SP fell and landed on top of the AV.

FM1 was told that the SP rolled his/her ankle which caused the SP to fall, and the SP also documented this in his/her written statement. However, video footage of the incident and the SP's account during his/her interview showed that the SP stepped over a bookshelf in the classroom and his/her foot got caught, causing the SP to fall and land on top of the AV. The AV sustained a broken femur.

The facility policy and training was to walk through gates and not step over them, and avoid stepping over objects while carrying children. The SP, P1, and P2 each stated that the bookshelf was placed where it was to keep children in the play area for a sustained period of time. Given that P1, P2, and P3 stated that staff were to walk around the bookshelf, or slide it out of the way instead of walking over it, and that the SP told this investigator that s/he stepped over the bookshelf while carrying the AV even though it was "common sense" not to do so, and that the SP tripped over the bookshelf and fell while carrying the AV, there was a preponderance of the evidence that there was 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 to protect a child from conditions or actions that seriously endanger the child's physical or mental health when reasonably able to do so).

Regarding the care of the AV after the fall:

Video footage of the fall showed that the SP landed on top of the AV during the fall. Although the SP told the DHS investigator that s/he did not think the AV hit his/her head during the fall because the SP had his/her hand on the AV's head, video footage showed the SP did not have his/her hand on the AV's head and when the SP rolled off the AV, the AV was face down with his/her head on a plastic ball.

The SP and P2 told the DHS investigator that after the fall, they checked the AV for injuries. P2 stated that s/he moved "everything" and there were no "red flags." The SP said s/he checked the AV for a concussion by checking the AV's pupil dilation right after the fall and the AV's pupils seemed "normal and reactive." P1 was called into the classroom right after the fall happened and stated that s/he touched the AV's arm, but stopped because the AV was upset due to not being familiar with P1. In addition, the facility's *Accident/Incident Report Form* stated that staff persons "checked [the AV] all over . . . We moved all limbs." However, video footage showed that after the fall the SP did not check the AV's eyes; and that P2 moved the AV's left arm and felt the AV's head, but did not specifically check any of the AV's other limbs, nor did any other staff person. Video footage showed the AV was

placed in his/her crib 16 minutes after the fall because s/he was falling asleep in the SP's arms.

The SP, P1, P2, and P3 each stated that the AV did not seem to have sustained a "major" injury based on his/her demeanor, noting that the AV seemed "tired" and like s/he was still not feeling "well," including during a diaper change by P3. However, the SP also stated that the AV was "not acting like [him/herself]" after the fall.

The SP stated that s/he called FM1 about 10-15 minutes after the fall, and P2 stated the call occurred within 30 minutes of the fall. During the call, the SP told FM1 the AV seemed "okay," that there was "no urgency" to come and get the AV, and if the AV's condition changed, the SP would let FM1 know.

The AV woke up from his/her nap at 10:13 a.m. P3 said s/he changed the AV's diaper and the AV was "fussy" and it seemed like s/he was not fully awake or that s/he did not feel well, but P3 did not notice anything "out of the ordinary" during the diaper change. About 90 minutes after the first telephone call, FM1 received another telephone call that the AV had a fever and needed to be picked up. At this time FM1 still thought the AV was not feeling well from his/her ear infection.

When FM1 arrived at the facility, the AV was in his/her crib and when P2 picked the AV up, the AV cried "really hard" and his/her hands were shaking. FM1 took the AV home and observed that the AV was in apparent pain, was trying to avoid movement, could not tolerate touch of his/her right leg, and his/her right leg was swollen. FM1 and FM2 took the AV to the emergency department where the AV was diagnosed with a broken right femur. The AV was transported to a specialty hospital where a spica brace was placed the next day. An emergency department doctor told FM1 that a femur break was the most painful break a human could have, and the AV received two doses of morphine to facilitate fitting and placement of the spica brace. FM1 did not understand how staff persons at the facility did not realize the AV was injured because anytime s/he tried to put the AV down or went near the AV's right leg, the AV screamed.

Given that the SP fell on top of the AV, that video footage showed that staff persons only checked the AV's left arm for injury but none of the AV's other limbs, that after the fall approximately two hours passed between the AV's fall and the facility's call asking FM1 to pick up the AV, during which time the AV had no medical attention or pain medication, and that the AV was later diagnosed with a fractured femur, there was a preponderance of the evidence that staff persons failed to provide the AV with necessary care 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).

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, P1, P2, P3, and P4 were each trained on the facility's *Emergency and Accident Policies* and the Reporting of Maltreatment of Minors Act. The SP, P1, P2, and P3 each had current First-Aid/CPR training and P4 had not yet received First-Aid/CPR training.

Regarding the fall:

P1, P2, and P3 each stated that when staff persons needed to go past the bookshelf they moved it out of the way in order to step around it. In addition, P1 stated that staff persons were trained to not step over a gate or enclosure while carrying a child, and P2 stated that s/he did not witness staff persons walk over the bookshelf "except that one time" (referring to the SP's fall while carrying the AV). However, given that video footage showed that during a one hour and fifty five minute video clip on a single date, multiple staff persons stepped over the bookshelf 26 times while carrying children in their arms (including in front of P1), and that the SP said s/he did this out of "habit," it was more likely than not a common practice at the facility for staff persons to step over the bookcase versus going around it. Therefore, the SP's responsibility was mitigated, and it was determined that the facility was responsible for the maltreatment of the AV.

Regarding the care of the AV after the fall:

Given that P4 was engaged with other children and did not assist in the care provided to the AV after the fall, P4's responsibility was mitigated. Although P3 stated s/he changed the AV's diaper after the incident and there was nothing out of the ordinary, given that the AV was only awake for 30 minutes while P3 was in the classroom, P3's responsibility was mitigated.

The SP, P1, and P2 each stated that they believed the AV had a minor injury based on his/her demeanor as s/he appeared to still not be feeling well, and that the facility's policy for minor injuries was followed. However, P2 did not move all of the AV's limbs as stated and documented, and the SP stated s/he followed concussion protocol by checking the AV's pupils for dilation, but that was not reflected in video footage. P2 notified P1 right after the fall and P1 had a significant administrative and supervisory authority over the operation of the facility and ensuring the facility maintained compliance with Minnesota Rules and Statutes.

Given that the SP1, P1, and P2 each failed to identify or communicate the seriousness of the fall and subsequent injury to FM1 or to call 9-1-1 as outlined for major injuries in the facility's *Emergency and Accident Policies-Emergencies*, and that P1 had a significant administrative and supervisory authority over the operation of the

facility the SP, P1, P2, and the facility were each determined to be responsible for the maltreatment of the AV.

C. Serious Maltreatment:

The Office of Inspector General is required to evaluate whether substantiated maltreatment by a facility meets the statutory criteria to be determined as "serious."

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 fall:

It was determined that the substantiated neglect for which the facility was responsible was "serious" maltreatment because the AV sustained a broken femur and required the care of a physician.

Regarding the care of the AV after the fall:

It was determined that the substantiated neglect for which the SP, P1, P2, and the facility were responsible was not "recurring" maltreatment because it was a single incident of maltreatment. In addition, it did not meet statutory criteria to be determined "serious" maltreatment because the delay in medical care did not cause additional injury to the AV.

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 found their policy and procedures were adequate, but not followed. The SP stepped over the bookshelf instead of going around it. The bookshelf was moved on March 14, 2024, so that it did not block access to the carpeted area. The *Internal Review* stated that the staff persons followed their

first aid training for a minor accident, that first aid was administered, and that the family members were notified. The SP no longer worked at the facility.

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

The SP, P1, and P2 were not disqualified from providing direct care services as a result of the maltreatment determinations in this report. However, the SP, P1, and P2 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 of the SP, P1 and/or P2. The determination that the SP, P1, and P2 were each responsible for maltreatment is subject to appeal.

On July 26, 2024, the license holder was ordered to forfeit a fine of $6,000 ($5,000 for one incident of determined maltreatment that was serious and $1,000 for determined maltreatment that did not meet statutory criteria for serious) as a result of the determined incidents of maltreatment for which the facility was responsible. The maltreatment determinations and the Order to Forfeit a Fine are each subject to appeal.

On July 26, 2024, the facility was issued a Correction Order for violations regarding diaper changing procedures.

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.