

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: 202404695

Date Issued: July 31, 2024

Name and Address of Facility Investigated:

New Horizon Academy
15300 Minnetonka Blvd
Minnetonka, MN 55345

Disposition: Maltreatment determined as to physical abuse of an alleged victim by a staff person.

License Number and Program Type:

801680-CCC (Child Care Center)

Investigator(s):

Anna Parkin
Minnesota Department of Human Services
Office of Inspector General, Licensing Division
PO Box 64242
Saint Paul, Minnesota 55164-0242
anna.parkin@state.mn.us
651-431-6225

Suspected Maltreatment Reported:

It was reported that there were concerns between a staff person's (SP) interactions with an alleged victim (AV) during carpet time and as a result, the AV sustained a laceration to his/her tongue.

Date of Incident(s): May 23, 2024

Nature of Alleged Maltreatment Pursuant to Minnesota Statutes, section 260E.03, subdivision 18, paragraph (a), and subdivision 23, paragraph (a):

"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 June 4, 2024; from documentation at the facility and video footage; and through four interviews conducted with a supervisory staff person (P1), two facility staff persons (P2 and the SP), and the AV's family member (FM).

According to the AV's enrollment information, the AV was two years and five months old and enrolled in the toddler room at the time of the incident.

Consistent information was provided that the SP and P2 were working in the toddler room at the time of the incident. In the middle of the toddler room was a carpet area and a chair that staff persons sat on to read during group time. Around the carpet area were small tables and chairs on wood floors. Along one side of the room was a diaper changing area.

P2 provided the following information:

- On May 23, 2024, at approximately 10:30 a.m., P2 changed some of the children's diapers while the SP did group time. The AV and a few other children ran around the room while other children were on the carpet. The AV ran around a small table and the SP got up and ran after him/her. The SP "aggressively" picked up the AV under his/her arms causing the AV to cry "right after" the SP picked up the AV. The AV did not have contact with a chair or anything in the area.
- The SP sat down on the chair by the carpet with the AV on his/her lap. The SP asked P2 for a wipe because the AV "hit" the chair and his/her tongue was bleeding. P2 gave the SP a wipe and gloves and then went to another staff person's (P3) room.
- P2 and P3 returned to the toddler room, P3 checked on the AV, and then went back to his/her room. P2 saw a "tiny hole" in the AV's tongue. P2 said that the AV possibly bit his/her tongue when the SP picked the AV up or set him/her down "too hard."
- The SP messaged the FM about the injury but did not complete an incident/accident report. Prior to this incident, when two other children (C1 and C2) and the AV did not behave, the SP placed them in a chair and buckled them in. [Note: This was a violation of Minnesota Rules, part 9503.0055, subpart 3, item G, which stated in part that the license holder must have and enforce a policy that prohibits the use of mechanical restraints.] The SP was also "a little aggressive" at times when talking to children.

Video footage provided by the facility showed the following:

- On May 23, 2024, at 10:44 a.m., the SP and approximately ten children including the AV were on or near the carpet. P2 was in the video but based on the angle of the camera, it was difficult to see what P2 was doing during a majority of the incident. The SP went and got the AV around the corner from the carpet and walked with the AV while holding one of the AV's hands. The SP led the AV to the carpet and the AV sat on the carpet near a chair.
- The AV immediately stood up and started to run away. The SP used one hand to grab the AV by his/her right forearm and quickly/forcefully pulled the AV backwards along the carpet approximately two feet. The AV landed on his/her buttocks on the carpet in front of the SP. The SP used two hands on the AV's arms to turn the AV to face towards the chair while the SP sat down in the chair. The other approximately

nine children stood on or near the carpet area.

- The AV turned around and began crawling away from the SP toward the other children. As the AV stood up to run away, the SP squatted on his/her legs and used his/her right hand and grabbed one of the AV's legs (it was difficult to see which leg because a child was stood in the view of the camera). The AV fell forward on his/her stomach onto the carpet and it appeared that his/her face hit the wood floor next to the carpet. The SP then dragged the AV backwards on his/her stomach approximately three feet to the chair that the SP sat back down on. The SP used both of his/her hands to pick up the AV off the floor and then roughly/forcefully sat the AV on the floor between the SP's legs.
- The SP interacted with two other children while the AV sat between the SP's legs on the carpet. At one point, the AV tried to stand but the SP put both of his/her hands on the AV's shoulders to keep the AV from standing. The SP continued talking to other children who began sitting down on the carpet. The AV crawled away from the SP, stood, and ran across the room to the table and chairs. The SP stood and followed the AV. The AV ran around a table and as the AV got close to a second table, the SP used his/her right hand to grab the AV. As the SP picked the AV up, it appeared as though the AV's head/face came into contact with a chair, because the chair moved, but it was difficult to determine exactly what part of the AV's head hit the chair because children were blocking the view.
- The SP then carried the AV under the SP's arm as the SP held the AV's torso. The AV put his/her hands near his/her face while being carried. The SP then sat the AV down in a rough manner on the carpet while the SP sat in the chair. The AV had a hand by his/her mouth and tried to move away but the SP used both of his/her hands to roughly slide the AV back between the SP's legs closer to the chair where the SP sat.
- The SP bent over and looked at the AV. The SP picked up the AV who was visibly crying and looked at the AV's mouth. The SP then spoke to P2 while the SP held the AV. P2 walked over and handed the SP a wipe and the SP put it on the AV's mouth.
- Based on a review of the video, at the time of the incident, the AV was not demonstrating unacceptable behavior that placed him/herself or others in danger.

The SP provided the following information:

- On the day of the incident, at approximately 11 a.m., the toddler children sat on the carpet for group time with the SP while P2 changed diapers. The SP told the AV, who was not on the carpet, to come to group time and the AV responded, "No." The AV then ran across the room. The SP said this was a game s/he played outside with the AV on the playground where s/he would catch the AV so the SP "assumed" that was what the AV was doing at the time of the incident.
- The SP stood up and followed the AV near the tables and chairs. The SP "grabbed" the AV by putting one hand on the AV's arms and one arm under the AV's torso. At the same time, the AV "flung" him/herself forward. The SP "believed" the AV hit his/her chin on one of the chairs because the chair tipped over. The SP was trained to pick up children under their arm pits and generally did not pick up children how s/he picked up the AV but did during the incident because the AV was running away from the SP.
- The SP carried the AV back to group time and noticed that the AV was bleeding from his/her mouth. P2

got wipes and the SP sat with the AV on his/her lap. The SP looked at the AV's mouth and saw a hole approximately the size of a bead in the AV's tongue. P3 came into the room and held the AV for awhile and the SP sent a message to the FM on the facility app. The SP gave the AV a cold pack to put on his/her tongue and the AV drank a glass of water.

- The SP was trained that if a child ran away from group time, s/he generally let them go but the AV had a history of running away and other children usually followed. The SP denied any other physical contact between the SP and the AV during the incident. When asked about grabbing the AV by one of his/her legs and dragged the AV backwards, the SP said s/he did not remember that happening.

P1 was on vacation on the day of the incident and at approximately 2 p.m., P3 texted P1 that the AV bit his/her tongue and P2 had concerns with how it occurred. P1 called another supervisory staff person (P4) to review video footage of the incident. The next day, P4 called P1 and described the video of the incident. The SP was suspended and P1 asked if s/he completed an incident report, and the SP said s/he had not. On May 28, 2024, P1 saw the AV and s/he still had a hole in his/her tongue but appeared "happy."

The FM was made aware of the incident and did not have any previous concerns with the facility.

According to the facility's *Behavior Guidance Policy*:

- Staff persons developed a "supportive, trusting relationship" with each child as a "foundation for discipline." Staff persons used "nurturing touch" and "engaged children in warm, playful interactions." Staff persons also viewed "challenging behavior" as a communication of "missing skills"; modified the environment; "clearly and positively" communicated expectations for children's behavior; gave children choices between two acceptable appropriate behaviors; offered empathy and validated the child's feelings; viewed mistakes as opportunities to learn new skills; and engaged children in "cooperative problem solving."
- The following actions were prohibited:
 - Corporal punishment including, but not limited to, rough handling, shoving, shaking, excessive tickling, slapping, kicking, biting, pinching, hitting, spanking, and pulling arms, hair or ears.
 - The use of physical restraint other than brief, supportive physical interactions by staff persons when a child was demonstrating "imminent physical danger" to him/herself and/or other persons with behaviors that were "significantly or persistently unsafe."

Facility documentation showed that staff persons interviewed for this investigation, including the SP, were trained on the *Behavior Guidance Policy* and the Reporting of Maltreatment of Minor's Act 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 enforced 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:

Video footage showed on May 23, 2024, at 10:44 a.m., the SP interacted with the AV in a physically aggressive manner including using one hand to quickly/forcefully pull the AV backwards along the carpet approximately two feet and the AV landed on his/her buttocks on the carpet in front of the SP; using one hand to grab one of the AV's legs as the AV was standing which resulted in the AV falling forward onto his/her stomach and hitting his/her face on the wood floor next to the carpet and then dragging the AV along the carpet; picking the AV up and roughly/forcefully setting the AV on the floor between his/her legs; and grabbing and picking up the AV near a table causing the AV's head/face to come into contact with a chair. Video footage did not provide definitive information to show at what point during the incident the AV bit his/her tongue. However, prior to the SP's interactions, the AV did not have an injured bleeding tongue, so it was determined that the SP's interactions with the AV caused the AV to sustain a hole in his/her tongue that bled. The SP's interactions with the AV were inconsistent with the standards of a professional caregiver in a program licensed by the Minnesota Department of Human Services; were violations of facility policies and procedures; and a violation of Minnesota Rules, part 9503.0055, subpart 3, item A.

The video showed that at the time of the incident the AV was not a danger to him/herself or others so there was no need for the SP to physically intervene with the AV. Therefore, there was a preponderance of the evidence that the SP's interactions with the AV were not accidental, represented a substantial risk of injury, 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).

B. Responsibility pursuant to Minnesota Statutes, section 626.556, subdivision 10e, paragraph (i):

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 was trained on the facility's *Behavior Guidance Policy* and the Reporting of Maltreatment of Minor's Act prior to the incident. The SP provided information that the manner in which s/he picked up the AV were not consistent with how s/he was trained. The SP was responsible for maltreatment of the AV.

C. Recurring and/or Serious Maltreatment:

The Office of Inspector General is required to evaluate whether substantiated maltreatment by an individual meets the statutory criteria to be determined as "recurring or serious." Individuals determined to be responsible for recurring or serious maltreatment are disqualified from providing direct contact services.

Minnesota Statutes, section 245C.02, subdivision 16, states:

"Recurring maltreatment" means more than one incident of maltreatment for which there is a preponderance of evidence that maltreatment occurred and that the subject was responsible for the maltreatment.

Minnesota Statutes, section 245C.02, subdivision 18, states:

"Serious maltreatment" means sexual abuse, maltreatment resulting in death, neglect resulting in serious injury which reasonably requires the care of a physician whether or not the care of a physician was sought, or abuse resulting in serious injury. For purposes of this definition, "care of a physician" is treatment received or ordered by a physician, physician assistant, or nurse practitioner, but does not include diagnostic testing, assessment, or observation; the application of, recommendation to use, or prescription solely for a remedy that is available over the counter without a prescription; or a prescription solely for a topical antibiotic to treat burns when there is no follow-up appointment. For purposes of this definition, "abuse resulting in serious injury" means: bruises, bites, skin laceration, or tissue damage; fractures; dislocations; evidence of internal injuries; head injuries with loss of consciousness; extensive second-degree or third-degree burns and other burns for which complications are present; extensive second-degree or third-degree frostbite and other frostbite for which complications are present; irreversible mobility or avulsion of teeth; injuries to the eyes; ingestion of foreign substances and objects that are harmful; near drowning; and heat exhaustion or sunstroke. Serious maltreatment includes neglect when it results in criminal sexual conduct against a child or vulnerable adult.

It was determined that the substantiated physical abuse for which the SP was responsible was not "recurring" because it was a single incident but was "serious" maltreatment because the AV sustained a laceration on his/her tongue that bled.

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 policies and procedures were adequate but not followed. The SP no longer worked at the facility.

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

The SP was disqualified from a position allowing direct contact with, or access to, persons receiving services from 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. The determination that the SP was responsible for maltreatment and the disqualification of the SP are each subject to appeal.

On July 31, 2024, the facility was issued a Correction Order for the violations outlined in this report and failing to complete an incident 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.