

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: 202405962

Date Issued: August 7, 2024

Name and Address of Facility Investigated:

Lil' Explorer Childcare of St. Michael
4123 Oakwood Parkway NE
Saint Michael, MN 55376

Disposition: A nonmaltreatment mistake to an alleged victim by two staff persons was not maltreatment.

License Number and Program Type:

1113172-CCC (Child Care Center)

Investigator(s):

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Suspected Maltreatment Reported:

It was reported than an alleged victim (AV) was unsupervised in a preschool classroom for approximately eight minutes.

Date of Incident(s): July 10, 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 July 24, 2024; from documentation at the facility; and through four interviews conducted with a facility supervisory staff person (P), two staff persons (SP1 and SP2), and the AV's family member (FM).

The facility had multiple classrooms, including an "early" preschool classroom. The early preschool classroom door opened directly into a large gym, had an exterior door that opened to an enclosed playground for the early preschool classroom, and also had a bathroom attached. Both the gym and early preschool classroom had video cameras.

The AV was three years old at the time of the incident and enrolled in the early preschool classroom. The AV enjoyed animals, reading books, and puzzles.

The facility *Name to Face Roster* showed that on July 10, 2024, SP1 and SP2 worked in the AV's classroom. At 3:45 p.m., SP1 and SP2 took the AV's classroom to the gym. At this time, there were 11 children in the room, including the AV. At 3:50 p.m., a child was picked up by a family member. At 4:01 p.m., the AV was picked up by the FM.

The FM provided the following information:

- On July 10, 2024, the FM arrived at the facility to pick up the AV and went into the gym, where the AV's class was. The FM "walked around the gym," but did not see the AV. The FM then asked SP1 where the AV was. SP1 then left and went into the classroom and the FM followed. When SP1 opened the classroom door, the FM and SP1 found the AV sitting by him/herself in a "corner" of the classroom. SP1 and the FM asked the AV if s/he was "okay" and the AV began talking about a band-aid s/he that had on. The FM did not think the AV "understood" that s/he was unsupervised. The AV was not hurt and was sitting in the corner not doing "anything," which was "unlike" the AV who typically did not like to "sit and not do anything."
- SP1 told the FM that the AV was unsupervised "not very long." SP1 was "crying" and "really upset" regarding the incident.
- The FM then told the P about the incident who said that s/he would "check the cameras." Approximately one hour later, the P called the FM stating that s/he looked at video footage of the incident and that the AV was unsupervised for "around two minutes."

The P provided the following information:

- On July 10, 2024, at some time after 3:50 p.m., the FM told the P about the incident. The FM provided information to the P that was consistent with the information the FM provided during his/her interview.
- The P reviewed video footage from the incident which showed that around 3:50 p.m., the AV's class gathered by the classroom door to go to the gym. SP1 was at the door with the children and was holding a clipboard which contained the names of the children for a name to face count. During this time, SP2 walked around the classroom putting toys away and was looking around. SP2 then joined the class by the

door. SP1 did a name to face count and opened the door to the gym. Once in the gym, SP1 and SP2 had the children line up against a wall but one child ran away from the group as SP1 was attempting to do a name to face count. Additionally, during this time, a parent also came to pick up a child. The parent began talking to SP1 and the children "saw their opportunity" and began playing in the gym. SP1 and SP2 did not notice that the AV was not with the group. Based on the video footage, the AV was unsupervised for approximately eight minutes. The P was not aware of the AV being unsupervised for two minutes.

- The P said that once they got to the gym and the "distraction" of the parent picking up was "over," SP1 and SP2 should have "rechecked" their name to face counts and ensured they had "eyes on each child to match up to their name."
- While the AV was unsupervised in the classroom, the AV was not visible on the video footage due to the position of the camera.
- The P spoke to SP1 and SP2 about the incident and was told that the AV was found in his/her classroom behind a "large" easel that blocked the "line of sight." The easel was not typically in the room but was there for an activity that day. The name to face procedure was done by SP1 and SP1 had marked the AV as with the group when the AV was "not actually with the group." SP1 said that s/he "thought" s/he saw the AV. SP2 had also walked around the room to do a "sweep" prior to leaving the room but did not see the AV behind the easel.
- The AV was not injured and not crying when found by SP1 and the FM. There were "no immediate" risks to the AV being unsupervised in the classroom because it was "child proofed" and age appropriate to the AV. However, the AV could have exited the classroom and went outside to the enclosed playground.
- Both SP1 and SP2 were responsible for the supervision of the AV at the time of the incident. There were no similar incidents with SP1, SP2, or the AV.
- Staff persons were trained "multiple times" regarding the supervision of children and name to face procedures. The name to face checks were documented on a paper roster. Staff persons were trained to count the children when they went to the gym and once back in their classroom.

SP1 and an untitled document written by SP1 provided the following information:

- At some point on the afternoon of July 10, 2024, SP1 and SP2 assisted the children in the AV's classroom to play with toys on a rug. When it was time to go to the gym, SP1 and SP2 assisted the children with cleaning up and lining the children up at the door. SP2 "checked corners" for children while SP1 conducted a "name to face" count, which the AV was a part of and documented this on a clipboard. At some point during this time, another child needed assistance so SP1 "stepped away" to assist that child. When SP1 finished with the child, SP1 and SP2 opened the classroom door so that the children could enter the gym and line up along a wall for another name to face count in the gym. However, during this time, when the children were lined up against the wall, a parent came into the gym to pick up their child so SP1 was "distracted" talking to the parent. As SP1 was talking to the parent, the children began to play so the name to face check in the gym was "incomplete."

- After the child left, the children played but “something did not feel right.” SP1 “kept counting” and “kept getting nine kids,” which was the number of children in the classroom (Note: Documentation showed that there were 10 children during this time, including the AV).
- At some point while they were in the gym, the FM arrived to pick up the AV. SP1 and the FM did not see the AV in the gym so SP1 and the FM “panicked.” SP1 and the FM went in the classroom and found the AV in a “corner” “just sitting there.” There were no injuries to the AV, the AV was not crying, and did not say anything. Potential risks to the AV being unsupervised included “sensory bottles” that were on a nearby “rack” that could have “fallen” on the AV but the AV was not able to open doors to get outside.
- SP1 said that based on the video footage, the AV was unsupervised for eight minutes.
- SP1 and SP2 were both responsible for the supervision of the AV at the time of the incident.

SP2 and a document titled *Statement* and written by SP2 provided the following information:

- On July 10, 2024, around 3 p.m., SP2 arrived to the facility for his/her scheduled shift and began working in the AV’s classroom with SP1. Around 3:30 and 4 p.m., SP1 and SP2 called the children to line up to go to the gym. SP2 “looked around the classroom” to ensure “everyone” was in line. SP1 then did a name to face count which included calling each child’s name and looking at the children to ensure they were present. Staff persons documented once each child was called. The class then went into the gym and SP1 did a second name to face count by having the children line up in the gym and then the children began playing.
- After approximately 10 to 15 minutes of being in the gym, the FM came to pick up the AV and SP1 and SP2 realized the AV was not in the gym. SP1 went “straight” to the classroom and found the AV hiding behind an easel. The AV was “okay.” SP2 thought the AV was unsupervised for “maybe” ten minutes. Although the AV was not injured, there were a “lot of risks” to the AV being unsupervised, including risks in the bathroom or the AV “getting hurt.”
- Although SP2 looked around the classroom prior to leaving for the gym, SP2 thought s/he “missed” seeing the AV because the AV was “hiding” behind the easel. During the counts, SP2 did not hear SP1 call the AV’s name and did not know how SP1 missed calling the AV. There was nothing out of the ordinary on the date of the incident and SP2 did not recall any distractions.
- SP2 did not recall how many children were present at the time of the incident but said that the classroom was in ratio.
- Staff persons were trained to do name to face counts during transitions to the gym four different times, including: prior to leaving the classroom, once they got to the gym, once it was time to return to the classroom, and once they had returned to the classroom.
- When there were two staff working in a classroom, such as on the date of the incident, both staff persons were responsible for ensuring the supervision of children. SP2 did not have any concerns with SP1’s supervision of children, including on the date of the incident.

Video footage from the incident showed the following:

- The facility had video footage of the incident from both the gym and the AV's classroom. The footage did not have sound. The video footage from both the gym and the AV's classroom did not show the entire area due to the camera angle. The footage from within the classroom showed the classroom door, parts of the bathroom, and some areas of the room but did not show the area where the AV was found.
- Video footage from within the classroom showed that on July 10, 2024, at 3:46 p.m., multiple children were with SP1 and SP2 on a classroom rug. SP1 and SP2 then began putting toys away and around 3:47:10 p.m., children began going towards the closed classroom door with SP1 who was holding a clipboard. During this time, SP2 was cleaning toys up with a child and then this child and SP2 went to the door with SP1 and the other children and then all the children sat on the floor near the door. At 3:48:28 p.m., SP1 was near the classroom door that led to the gym. However, due to the angle of the camera, this investigator was not able to see what SP1 was doing, aside from holding the clipboard and standing in front of the children near the door.
- At 3:49:20 p.m., SP1 opened the classroom door and children began walking into the gym. At 3:50:08 p.m., all the children that were visible on the camera left the room and SP2 shut the door, as s/he was the last to leave.
- The footage from the gym showed that at 3:49:18 p.m., the early preschool door opened and children began walking into the gym and lining up at a nearby wall. However, one of the children began running around the gym. SP1 and SP2 followed the children out of the classroom and into the gym and SP1 was holding a clipboard. There were 10 children who came out of the classroom.
- At 3:50:28 p.m., a parent came to pick up one of the children and began talking to SP1. During this time, some of the children left the wall and SP1 appeared to be documenting on the clipboard. At 3:50:58 p.m., the parent and child left the gym and all the children began playing. SP1 and SP2 then began walking around the gym with the children. There were nine children during this time. However, around 3:52:20 p.m., another class came into the gym. SP1 and SP2 continued to walk around the gym, interacting with the children. During this time, SP1 also appeared to look at the clipboard and document on there.
- At 3:57:30 p.m., the FM walked into the gym and appeared to be looking for the AV. SP1 then appeared to also be looking around the gym for the AV. At 3:58:03 p.m., SP1 and the FM walked to the early preschool room and opened the door and went inside. SP2 remained in the gym with the other children.
- Meanwhile in the classroom between 3:50:08 and 3:58:04 p.m., no one, including the AV, appeared within view of the camera in the classroom. At 3:58:05 p.m., SP1 and the FM walked into the classroom and appeared to be looking around. Then they both went out of the camera view towards the back of the room. At 3:59:30 p.m., the FM came into view of the camera holding the AV and SP1 was behind them. The AV did not appear to be crying. The video footage then stopped.

The *Supervision Procedures Name to Face and Transition Policy* said that "every" staff person was to know how many children they had at "all times." The name to face checks were to be done once each hour throughout the

day, in addition to whenever a child/teacher arrived or left and “no less than every 30 minutes at a minimum” during drop off/pickup. To ensure that children were not left in classrooms, staff persons were to complete the “transition portion of the attendance roster.” This included that during each transition, staff persons were to note “every child” in their care by looking at the child and then checking the box under the designated transition and time. Staff persons were to do four checks during transitions. This included prior to leaving for the destination, once they arrived to their destination, when it was time to return to the classroom, and once back in the classroom. Staff persons were to position themselves to see and hear children at all times and interact with children.

The *Risk Reduction Plan* said that children were to be monitored at all times. When children were moving through the facility, staff persons were to do head counts and name to face counts, including when exiting and entering a new room. Staff persons were to continuously move about an area to keep a close watch on children.

Facility documentation showed that SP1, SP2, and the P received training on the facility’s name to face check procedures, the facility’s Risk Reduction Plan, and the Reporting of Maltreatment of Minor’s Act prior to the incident.

Relevant Rules and/or Statutes:

Minnesota Statutes, section 245A.02, subdivision 18, and Minnesota Rules, part 9503.0045, subpart 1, item A stated that a child must have supervision at all times and that supervision was defined as occurring when a program staff person is within sight and hearing of a child at all times so that the program staff person can intervene to protect the health and safety of the child.

Conclusion:

Information was consistent from all sources that on July 10, 2024, the AV was left in the preschool classroom for approximately eight minutes without the knowledge or supervision of staff persons which was inconsistent with the facility’s *Risk Reduction Plan and Supervision Procedures Name to Face and Transition Policy*; and was a violation of Minnesota Statutes, section 245A.02, subdivision 18, and Minnesota Rules, part 9503.0045, subpart 1, item A.

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

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

(4) any injury to a child resulting from the incident, if treated, is treated only with remedies that are available over the counter, whether ordered by a medical professional or not; and

(5) except for the period when the incident occurred, the facility and the individual providing services were both in compliance with all licensing requirements relevant to the incident.

Consistent information was provided that at the time of the incident, SP1, SP2, and the children left the classroom to go to the gym, and SP1 and SP2 were supervising children in the gym. Although the AV was alone for eight minutes and SP1 and SP2 were not aware that the AV was left in the preschool room, SP1's and SP2's actions or conduct were determined to be a nonmaltreatment mistake for the following reasons:

(1) SP1 and SP2 both stated that SP1 completed a name to face count and documented it prior to leaving the classroom. SP1 and SP2 attempted to complete a second count once they arrived to the gym but were interrupted when a parent came to pick up another child. Additionally, SP2 did a "sweep" of the classroom and "checked corners" but did not see the AV as s/he was behind an easel. While in the gym, video footage showed that SP1 and SP2 were both interacting with the children, including walking around, and SP1 appeared to look at the name to face counts on the clipboard at various points.

(2) SP1 and SP2 have not previously been found responsible for a similar incident that resulted in a finding of maltreatment or a nonmaltreatment mistake in the past.

(3) SP1 and SP2 have not previously been found responsible for a similar incident that resulted in a finding of a nonmaltreatment mistake in the past.

(4) The AV was uninjured and did not require medical care after the incident.

(5) Outside of this incident, the facility, SP1, and SP2 were in compliance with all relevant licensing requirements.

The nonmaltreatment mistake to the AV by SP1 and SP2 was not maltreatment.

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

Action Taken by Facility:

The facility completed an internal review and determined that policies and procedures were adequate but not followed. This included that a name to face count was done by SP1 with SP2 present, but the AV was "checked off incorrectly." SP1 and SP2 failed to ensure supervision using correct "execution of name to face and sweep of [the] classroom." The facility retrained staff persons on supervision policies, including name to face, and the safety and supervision manual.

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

SP1 and SP2 were not determined as a perpetrator of maltreatment of the AV because the Department of Human Services found that the incident for which SP1 and SP2 were responsible met the criteria to be determined a

nonmaltreatment mistake. SP1 and SP2 were notified by the Office of Inspector General that any future incident of possible neglect of an alleged victim for which SP1 or SP2 were responsible might not be considered a nonmaltreatment mistake.

In addition, on August 7, 2024, the facility was issued a Correction Order for the violation outlined in this report and for failing to implement an individual child care program plan for the AV.

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.