DEPARTMENT OF HUMAN SERVICES

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: 202406133

Date Issued: September 27, 2024

Name and Address of Facility Investigated:

Yellow Brick Road ECDC
12760 Anderson Lakes Parkway
Eden Prairie, MN 55344

Disposition: Maltreatment determined as to neglect of an alleged victim by two staff persons.

License Number and Program Type:

1095980-CCC (Child Care Center)

Investigator(s):

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Suspected Maltreatment Reported:

It was reported that two staff persons (SP1 and SP2) left an alleged victim (AV) unsupervised on the playground for one to three minutes. Another staff person (P1) discovered the AV and brought him/her inside. The AV was unharmed.

Date of Incident(s): July 11, 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 August 22, 2024; from documentation at the facility; and through interviews conducted with the AV's family member (FM), facility staff persons (SP1, SP2, and P1), and a supervisory staff person (P2).

At the time of the incident, the AV was 34 months old and enrolled in the preschool classroom.

The facility provided childcare services in a stand-alone building at the intersection of Flying Cloud Drive with speed limits of 50 miles per hour (mph) and Anderson Lakes Parkway with speed limits of 35 mph. The surrounding area included a strip-mall with more than one restaurant, a dental office, and a grocery store; a lake; a wooded area; a research and development company, which shared a parking lot entrance with the facility; and more than one residence.

There were playgrounds attached to the north and east sides of the building with chain-link fencing fully enclosing and separating the playgrounds from two parking lots, one for the research and development company and the other for the facility.

The AV's preschool classroom had an exterior door that opened into the north playground. There was then a chain-link fence with a gate separating the preschool playground from the playground on the east side of the building. The east playground was typically used for "water play" days. The east playground had more than one bench, a grassy area, water hoses and tables, and two brick structures about three to four feet high enclosing the facility's heating and cooling units. For the preschool classroom to access the water play area (east playground), they had to go out their exterior door, walk around the corner of the building, and through the gate. It was not possible to see the water play area from the preschool classroom door or windows. [Note: There were cameras mounted around the building, which recorded activity in the parking lot, but did not cover the playgrounds where the incident occurred.]

The pre-kindergarten classroom had windows and a door that directly opened to the water play area (east playground).

The facility's "*Ouch Report*" stated that on July 11, 2024, at 11:20 a.m., the AV was left in the water play area alone (unsupervised) after the rest of his/her class went inside to change out of their swimsuits. P1 discovered the AV on the playground and brought him/her to the preschool classroom, and then notified P2.

The FM said that s/he was notified of the incident by P2 "a few days after" it happened. The FM had no specific concerns relating to the incident but said the facility had a lot of staff turnover.

SP1 and SP2 provided the following information:

- On July 11, 2024, around 11:20 a.m., SP1 and SP2 were in the water play area with 17 children, including the AV. [Note: SP2 said that s/he incorrectly believed they had 16 children at the time.]

- SP1 prepared to take half of the children inside to change out of their swimsuits, which left SP2 outside with the other half. SP1 said that s/he initially told SP2 that s/he was taking nine children ("friends") inside and SP2 said, "Okay." However, as SP1 was leaving, one child left the line and returned to the playground. SP1 then told SP2, "I lied. I'm taking eight friends only. That leaves you with the other nine."

According to SP1, SP2 responded, "Okay."

- SP2 said that s/he heard SP1 state s/he was taking eight children inside. At that time, SP2 believed they had 16 children total and so with SP1 taking eight inside, SP2 believed, at the time, "I was left outside with eight." "Less than five minutes" after SP1 went inside, SP2 gathered the remaining children and also went inside. [Note: SP1 said that SP2 came inside "about 15 to 20 minutes" after SP1.]

- SP2 led the children to the gate between the east and north playgrounds and counted them. "I counted eight." "What I'm assuming happened was, when I counted, there was a kid who was trying to climb on the fence, and I put them down, and [the AV], [s/he] walked away and hid in a little corner outside." SP2 then led the children around the building and inside closing the door behind them. SP2 said that s/he should have counted the children upon arriving inside; however, s/he did not. SP2 was trained to count the children before going inside or outside and again when they arrived at their destination. However, water play days were "chaotic" and SP2 was busy changing swimsuits, and the children were throwing their towels around. "So, I just, I don't know what I was thinking. I just didn't count that time." About one and a half minutes after arriving inside, P1 arrived at their exterior door with the AV in hand. SP2 did not know the AV was missing during that time. The AV was not injured.

- SP1 also was trained to count the children; however, did not do so when SP2 arrived in the classroom with the remaining children. "I was still in the bathroom, changing (swimsuits) but I asked [SP2] if [s/he] grabbed everybody from outside" and SP2 said, "Yes." SP1 believed P1 brought the AV to their door five to ten minutes after SP2 arrived inside.

- SP2 told the DHS investigator that s/he was 17 years old and because of this, s/he should not have been left outside alone with children.

- When asked about SP2's age, SP1 said that s/he thought SP2 was 18 years old because SP2 had just had a birthday, which SP1 believed was his/her 18th birthday. (Note: On July 11, 2024, the date of the incident, SP2 was 16 years old. Minnesota Rules part 9503.0034, subpart 1, states that an aide who is under 18 years old must be directly supervised by a teacher or assistant teacher at all times, except when the aide is assisting with the supervision of sleeping children or assisting children with washing, toileting, and diapering. Leaving SP2 as the sole staff person supervising children on the playground was a licensing violation.)

P1 provided the following information:

- Around 11 to 11:20 a.m., P1 was inside the pre-kindergarten classroom gathering a group of children for an activity when s/he heard "beating" and "screaming or yelling" from the classroom windows, overlooking the water play area. P1 initially thought it was one of his/her own students but then saw the AV standing outside "beating on the window."

- P1 did not immediately see any other children or staff on the playground. P1 opened the exterior door and upon looking again did not see anyone outside with the AV. The AV was crying and repeatedly saying, "[Mommy/Daddy]." The AV was not injured but "looked scared."

- P1 recognized the AV and which classroom s/he was supposed to be in and was aware the AV's classroom

had been in the water play area just prior. P1 did not know when the AV's classroom went inside or how much time had passed since they went inside. P1 told the other staff person in the pre-kindergarten classroom and then walked with the AV outside, around the building, to the preschool classroom door. P1 met SP1, who immediately asked SP2 if s/he had counted prior to coming inside. P1 could not recall what more was said between SP1 and SP2, before ensuring the AV was okay and then leaving to return to his/her classroom.

- P1 was trained to count the children during every transition, including at every door or gate. P1 was also trained to communicate with other staff persons in the classroom to ensure they were counting the same numbers. The facility had an application (app) called "kangaroo time," which tracked attendance on each classroom's tablet. Staff were not required to look at kangaroo time during every count or to mark kangaroo time in any way to document a count. However, P1 added, "You're supposed to know how many (children) you have at all times. You don't guess. You know."

P2 provided the following information:

- Based on SP1's, SP2's, and P1's statements, P2 estimated the AV was unsupervised for "not more than few minutes" or "for approximately two to three minutes." The AV was unharmed.

- P2 had no prior concerns with SP1's and/or SP2's conduct and neither had a history of leaving children unsupervised.

- All staff were trained on counting children during transitions. When leaving the water play area, staff were supposed to have the children line up and then count them in line. If the count was off at that time, the staff checked the playground. Once all children were accounted for and in line, the staff led them to the gate and counted them again. Next, they went to the exterior door, at which point they counted again, and then again counted once all were inside. These counts could be a head count or a name to face count. Staff were not required to check kangaroo time or document their counts using kangaroo time.

- Regarding SP2's age at the time of the incident, P2 said that SP1 was aware that SP2 was a minor. All staff, including SP1, were informed of SP2's age on SP2's first day of employment. "Our expectations for this scenario are that [SP1] would have reached out to [an administrative staff person] or another available staff member to step in or switch with [SP2] or they all would have gone in together." "We inform staff on their first day who is under 18 and able to be left alone in classrooms."

The facility's *Risk Reduction Plan* stated the following:

- When on the playground, staff positioned themselves and continuously walked around to maintain supervision within sight and sound of all children and areas difficult to supervise. Staff periodically counted the children and ensured all were accounted for.

- Children were not permitted to open the playground gates.

- Staff completed head- or name to face- counts every time they left one space and entered a new space.

Facility documentation stated that SP1, SP2, P1, and P2 received training on the facility's *Risk Reduction Plan* and

the Reporting of Maltreatment of Minors Act.

Relevant Rules and Statutes:

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

Conclusion:

A. Maltreatment:

On July 11, 2024, SP1 and SP2 were on the "water play" playground with 17 children, including the AV. When SP1 and SP2 brought all of the children inside, the AV was left on the playground unsupervised for around three minutes which was a violation of Minnesota Statutes section 245A.02, subdivision 18, and Minnesota Rules, part 9503.0045, subpart 1, item A.

The AV, who was 34 months old, was left unsupervised on the playground, which was visible from two different parking lots and was therefore exposed to community dangers. Given the AV's age, it was unlikely that the AV would have been able to provide for him/herself in an emergency and staff persons were unaware the AV was on the playground and therefore, would have been unable to respond in the event of an emergency and/or intervene if necessary. Therefore, there was a preponderance of the evidence that there was a failure to supply the AV with necessary care and/or protect the AV from conditions 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; 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.

On the day of the incident, SP1 and SP2 were responsible for the care and supervision of the children including the AV. SP1 and SP2 received training on the facility's *Risk Reduction Plan* and the Reporting of Maltreatment of Minors Act.

SP1 took a group of children from the playground into the classroom, leaving SP2 on the playground with nine children including the AV. SP2 said s/he thought s/he had eight children and counted when s/he left the playground but did not count when s/he returned into the classroom. In addition, neither SP1 nor SP2 counted the children once they were all inside.

Although SP2 was 16 years old at the time of the incident and therefore, should not have been the sole staff person supervising the children on the playground, this did not mitigate his/her responsibility to know how many children s/he was supervising or to ensure that all of the children, including the AV, returned inside.

Although SP1 was not responsible for the AV's supervision once SP1 took his/her group of children inside and said that because SP2 had recently had a birthday, s/he thought SP2 was 18 years old, SP2's birthday was after the incident and at the time of the incident SP2 was 16 years old. P1 stated that SP1 was aware that SP2 was underage. Given that SP1 allowed SP2, who was 16 years old, to supervise children on the playground, SP1 had a greater responsibility to ensure that all of the children returned into the classroom and therefore, his/her responsibility was not mitigated.

SP1 and SP2 were 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 neglect for which SP1 and SP2 were responsible did not meet statutory criteria to be determined as recurring or serious. SP1 and SP2 were each responsible for a single incident of maltreatment for which the AV did not sustain a serious injury.

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 at the time of the incident. "Name to face was not performed by the classroom staff upon re-entering the classroom, or leaving the playground … All staff were retrained on name-to-face attendance." There was not a history of such incidents at the facility or with the AV, SP1, and/or SP2.

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

SP1 and SP2 were not disqualified from providing direct care services as a result of the maltreatment determination in this report. However, SP1 and SP2 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 SP1 and SP2 were each responsible for maltreatment is subject to appeal.

On September 27, 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.