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: 202403378

Date Issued: October 4, 2024

Name and Address of Facility Investigated:

Urban Ventures Cornwell Early Learning Center
2924 4th Ave S.
Minneapolis, MN 55408

Disposition: Maltreatment determined as to neglect and physical abuse of nine alleged victims by a staff person.

License Number and Program Type:

1101596-CCC (Child Care Center)

Investigator(s):

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Suspected Maltreatment Reported:

It was reported that a staff person (SP) "harshly" dragged an alleged victim (AV1) by the arm which left a red mark on AV1's arm. According to the report, this was the second incident of a similar nature within one month involving the SP and AV1. During the course of this investigation, information was obtained that showed the SP hit, pushed, and/or grabbed eight other alleged victims (AV2-AV9).

Date of Incident(s): March 28 and April 16, 2024

Nature of Alleged Maltreatment Pursuant to Minnesota Statutes, section 260E.03, subdivision 15, paragraph (a), clauses (1) and (2); subdivision 18, paragraph (a); and subdivision 23, paragraph (a):

Failure by a person responsible for a child's care to supply a child with necessary food, clothing, shelter, health, medical, or other care required for the child's physical or mental health when reasonable able to do so.

Failure to protect a child from conditions or actions that seriously endanger the child's physical or mental health when reasonably able to do so.

"Physical abuse" means any physical injury, mental injury, or threatened injury, inflicted by a person responsible for the child's care on a child other than by accidental means. "Threatened injury" means a statement, overt act, condition, or status that represents a substantial risk of physical or sexual abuse or mental injury.

Summary of Findings:

Pertinent information was obtained during site visits conducted on May 1 and May 8, 2024; from documentation at the facility; and through 15 interviews conducted with a supervisory staff person (P1), seven facility staff persons (SP, P2-P7), and family members for AV1-AV6, and AV9 (FM1-FM6, and FM9 respectively). P2 was also AV1's family member.

This investigator also reached out to an additional staff person (P8) by email, telephone, and mail to request an interview, but P8 did not provide information to this investigator.

This investigator also reached out to AV7's and AV8's family members (FM7 and FM8 respectively), but they did not provide any information to this investigator.

AV1-AV9 ranged in ages from 25-34 months and attended classrooms at the facility based on their age. Due to their ages, AV1-AV9 were not interviewed for this investigation.

The facility was located on the second floor of a community center and had its own secure entrance from the lobby. The facility had six classrooms serving infant through preschool aged children. The Green toddler classroom had a door with a large window cut out in it and there were two floor to ceiling windows next to the door. These looked out into an open main area. The Green toddler classroom shared a bathroom and diaper changing area with the Blue toddler classroom. There was also a large window between the two classrooms.

The facility utilized a gym within the community center. The gym had a divider in place, and the facility had tricycles, hula hoops, balls, and other equipment for children to use while they were in the gym.

P2 provided the following information:

- On March 28, 2024, around 11 a.m., P2 was working in the Blue toddler classroom and heard AV1 scream. P2 looked through the window into the Green toddler classroom and saw the SP pull and shake AV1 while screaming at AV1 to "calm down." P2 told the SP it was not okay to pull AV1 like that and the SP told P2 that s/he was "frustrated."

- The next day, P2 went to P1 to tell him/her about the situation. P1 said that was not supposed to happen, but "nothing was done."

- On April 16, 2024, sometime between 9 and 10 a.m., the Blue toddler and Green toddler classrooms were in the gym. P2 went to the bathroom and when s/he returned s/he saw the SP "grab" and "pull" AV1 by the arm and the SP brought AV1 to another staff person. P2 went to AV1 and saw red finger-shaped marks on both of AV1's upper arms.

- In the past when P2 talked to P1 about his/her concerns regarding P5 hitting a child in the mouth, P1 told P2 that if s/he reported it, that P5 would lose his/her job. P1 advised P2 to tell P5 that what was okay at home with his/her own children, was not okay at the facility.

- P2 stated s/he was not trained on how to handle children if they were having a behavior incident such as if a child hit, kicked, or slapped a staff person. P2 said s/he hugged a child and told a child what hands are for when incidents like that happened.

FM1 provided the following information:

- On April 16, 2024, P2 told FM1 what happened to AV1 so when FM1 saw AV1 at home later that evening, s/he asked AV1 if s/he was okay. AV1 said, "Ow," and pointed to his/her left arm. FM1 noticed a mark on AV1's arm and took pictures of the mark. FM1 said the mark faded away by the next day.

- FM1 said that another incident happened with AV1 and the SP on March 28, 2024, and nothing was done by the facility to address it.

- On April 18, 2024, FM1 received an email from P1 thanking FM1 for bringing his/her concerns to the facility's attention and informing FM1 that staff persons were interviewed, and video footage was reviewed. P1 wrote that the facility was unable to identify any evidence of mistreatment of AV1 by any staff member, and video footage showed AV1 falling and an unspecified staff person helping AV1 up.

This investigator reviewed photographs received from FM1 that were taken on April 16, 2024, and noted a light red mark covering the back of AV1's left upper arm from where his/her t-shirt ended to his/her elbow.

This investigator received video footage from the facility from the Green toddler classroom on March 28, 2024, and from the gym on April 16, 2024, and observed the following:

Regarding the classroom video from March 28, 2024:

- At 26 minutes into the video footage, AV8 was seated on a carpet in the classroom and s/he took a toy off of a shelf. The SP was seated in a small chair approximately five feet away. The SP stood up and swatted at the toy in AV8's hand and then wiped AV8's nose. The SP went and threw away the wipe s/he used on AV8's nose, and then returned to the carpet and bent over facing AV8. AV8 had his/her right hand on a toy and the SP tapped AV8's right hand three times and then pushed AV8's hand off of the toy. The SP squatted down and picked up a few toys around AV8. When the SP stood up, s/he pulled AV8 by the right wrist from a seated to standing position, grabbed AV8 by his/her right elbow, and directed AV8 toward the bathroom area (where P3 was assisting children). The SP let go of AV8 after six steps. AV8 did not seem to be upset by the SP's actions.

- At 51 minutes into the video footage, AV2 and AV4 were seated on the carpet playing with instruments. The SP walked behind AV2 while s/he played with two tambourines and the SP hit AV2 on the back and pointed to a basket on a nearby table with music instruments in it. The SP walked over to pick up the basket and AV2 picked up a tambourine to put it on the toy shelf. The SP walked over by AV4 who was still seated on the carpet and kicked AV4's foot to prompt him/her put a toy into a basket. AV4 put the

instruments in the basket and then picked up the other tambourine AV2 left on the carpet.

- At 1 hour 13 minutes into the video footage, the children were seated at the table and AV2 was bent over in his/her chair. P3 sat AV2 up in his/her chair and appeared to be talking to AV2 when the SP walked behind AV2, squatted down next to AV2's chair and pulled the back of AV2's shirt hard enough that AV2 started to fall sideways off the chair. The SP talked to AV2, pushed AV2's chair in, then stood up, and walked away.

- At 1 hour 43 minutes into the video footage, the SP had the children start to clean up and sit on the carpet for group time. AV9 and AV2 were running around the classroom. AV9 was standing on the edge of the carpet when the SP grabbed his/her arm and pushed AV9 to the floor (AV9 appeared upset). As this happened, AV2 walked onto the carpet toward AV9 and the SP. The SP turned around and grabbed AV2 by his/her right elbow and dragged AV2 backwards until s/he was in a seated position next to AV5 on the other side of the carpet. The SP let go of AV2 and grabbed AV5 by his/her left hand and pulled him/her from a seated position into a standing position. AV5 fell to his/her knees, and the SP pulled up again on AV5's wrist to get him/her into a standing position. AV5 picked up a toy and a blanket that s/he had by him/her and walked out of view of the video footage. The SP walked over to the dramatic play area to help a few children pick up toys. AV3 ran by the SP about six feet from the dramatic play area with a toy in his/her hand, and the SP grabbed AV3's right wrist and pulled him/her over to the dramatic play area to put away the toy. AV3 then went and sat on the carpet in front of AV2. The SP went to the carpet, grabbed AV3 by his/her right upper arm, and pulled AV3 back until s/he was sitting next to AV2 instead of in front of AV2. (Note: all of these interactions took place in under a minute as the children were cleaning up and coming to sit on the carpet for group time).

- At 1 hour 56 minutes into the video footage, AV7 was seated behind another child and looking down at his/her hands when the SP made a swatting motion at AV7's hands. AV7's hands went apart and s/he looked up startled.

- At 2 hours 7 minutes into the video footage, the children were getting seated around tables. AV1 missed his/her chair and fell onto the floor. The SP walked by AV1's chair and as AV1 sat in the chair, the SP kicked the chair once to get the chair under AV1, then the SP went to the other side of the chair and kicked the chair again (AV1's body was jostled by the motion), and then the SP kicked the chair one more time to get it tucked under the table.

- At 3 hours and 2 minutes into the video footage, the children were cleaning up toys on the carpet before lunch. The SP was squatted down with a bucket for children to put toys in. AV6 threw a toy toward the bucket, and it missed landing on the other side of the bucket. The SP looked up and hit the top of AV6's head (AV6 was looking down at the floor). AV6 looked up startled. The children then went to the tables to sit down. AV1 bit AV6, then the SP went over and crouched down in front of AV1 and appeared to yell at AV1. The SP then took AV1's right hand, abruptly turned AV1 around, and walked him/her away from AV6. As s/he did so, the SP tugged at AV1's right hand. The SP then picked AV1 up by his/her upper arms and then repositioned and held AV1 as s/he cried and P3 checked on AV6. The SP walked out of view of the video footage with AV1.

Regarding the gym video from April 16, 2024:

- AV1 was on a tricycle when s/he rode into another child. The SP was approximately 20 feet away and was looking down at his/her cell phone. The SP looked up and walked over to AV1 and the other child. The SP motioned for AV1 to get off of the tricycle. The SP held AV1's right hand while AV1 got off the tricycle, and then they walked to the edge of the basketball court (the SP still held AV1's hand). AV1 tripped and fell to his/her knees. The SP bent down behind AV1 and picked AV1 up by his/her upper arms and carried AV1 over to another staff person who was sitting at the edge of the gym and only his/her feet were visible on the video footage.

- P2 entered the gym after AV1 got off of the tricycle, but before s/he tripped. After the SP brought AV1 to the other staff person, P2 interacted with another child and then went over to AV1, hugged AV1, and looked at AV1's arms.

- About two and a half minutes after the incident with AV1, a child approached the SP with a green bouncy ball. The SP tapped the ball out of the child's hands, bounced the ball on the floor, and then picked up the ball and bounced it off of the child's head. The child did not appear to be hurt. When the child went back over to the SP with the ball, the child put the ball down on the floor and the SP kicked the ball away from the child (the SP was on his/her cell phone during this interaction). During the 30 minutes of video footage provided, the SP was on his/her phone more than fifty percent of the time and was not engaged with the children in his/her care.

The SP provided the following information:

- The SP stated that s/he used a "strong" voice to get the children to listen to him/her, but that was his/her "normal" tone. If children did not listen, the SP took a child by the wrist.

- The SP stated that because s/he had a medical issue with his/her back, s/he grabbed a child under the arms when a child needed to be moved. The SP stated that the children cried when s/he did this because the SP moved the children, not because s/he grabbed them. The SP denied grabbing a child by the upper arms. The SP stated that if a child stopped walking when s/he was walking with them, s/he left the child alone. The SP stated s/he did not drag, grab, or shake a child "by intention." The SP denied leaving marks on a child.

- The SP stated that if a child was seated, the SP stretched his/her hand to help a child get to a standing position and had to use more "strength" to get a child up. The SP said that s/he could not bend to pick a child up from that position and had to take hold a child by the wrist. The SP stated that the children's feet did not leave the floor because the SP was not that "strong."

- The SP stated that when children threw toys, s/he showed the children how to pick up toys instead. The SP denied hitting a child and stated that was "totally false." The SP denied hitting, striking, swatting, tapping, popping, or smacking a child. (Note: when this investigator told the SP that video footage showed the SP do those things and asked the SP about that, the SP responded, "No, that is false, no one can tell me I hit a child.")

FM2-FM9 provided the following information:

- FM2 said AV2 recently moved into the Blue toddler classroom and the transition went well. FM2 had no concerns.

- About six or seven months prior to his/her interview, FM3 brought to P1's attention a concern with P2 and another unknown staff person "yelling" at AV3 one day when FM3 arrived early to pick AV3 up from the facility. FM3 also had concerns with AV3 having a diaper rash. FM3 stated there had been a lot of staff turnover.

- FM4 stated that AV4 was in the Green toddler classroom and FM4 had no concerns with the staff persons. FM4 did not remember the staff persons names, but stated they helped FM4 a lot.

- FM5 stated that AV5 was really happy when s/he saw staff persons at the facility. FM5 did have a concern that the SP was "frustrated" with AV5 when AV5 took off his/her shoes. FM5 could tell by the SP's tone of voice that s/he was frustrated and FM5 was surprised because s/he thought it was a normal event, but the SP was "up in arms" about it.

- FM6 had no concerns with the SP and stated that s/he was a "very nice teacher."

- FM9 stated that s/he did not have concerns, but "sometimes" thought AV9 was hit by another child when the children were playing because AV9 came home with bruises.

P3-P7 provided the following information:

- P5 stated s/he worked in the classroom with the SP and P3. When the SP talked the children listened, as his/her voice was "demanding and loud." P5 initially said s/he did not witness the SP hit or grab a child, but later during his/her interview P5 stated that when AV1 did not listen, the SP "grab[bed]" AV1's hand "not hard" and sat him/her down "soft[ly]" in a chair. (Note: P5's interview was conducted with an interpreter, and it was possible that the apparent conflicting information about whether the SP grabbed children was the result of a translation imprecision.) P5 stated that AV1 cried "sometimes" when that happened. P5 stated that s/he had taken AV1 "softly" by the arm before and it had left a mark.

- P5 stated that s/he tried to distract a child and calm him/her down if a child had a behavior issue. If a child needed to be moved to a different area, P5 said s/he picked that child up under the arms. P5 advised the SP to do the same instead of grabbing a child by the arm or wrist.

- P3 stated that on an unknown date AV2 was crying and s/he asked P8 what happened, and P8 told P3 that the SP "pushed" AV2 into a table and AV2 hit his/her stomach. On an unknown date, the SP grabbed a child (P3 did not remember who it was) by a leg and pulled the child down. The child fell to the floor.

- P3 stated that s/he did not see the SP hit or slap a child, but P3 did see the SP "aggressive[ly]" grab children and sit them down. P3 did not remember the date but stated after the incident in the gym s/he saw marks on AV1's arms. P3 demonstrated a hard grabbing motion on his/her own arm and pointed to marks left by his/her fingertips, indicating the marks on AV1's arms looked similar. P3 said the marks lasted between two and four hours. P3 asked the SP how AV1 got the marks, but the SP said s/he did not know.

- P3 stated s/he was trained that if a child was having a "tantrum" to leave the child be and when the child got up, to give them hugs. P3 stated s/he did bring concerns to P1 about how the SP treated children. P1 told the SP and then the SP approached P3 about it. P3 stated there was "no confidentiality" at the facility, and that was why staff persons did not want to do "anything" because they were afraid to lose their jobs.

- P7 stated on an unknown date, s/he was in the gym with the Green and Blue toddler classrooms. P7 was seated on the floor helping two children with their shoes. P7 saw the SP lift AV1 by his/her arm, pull AV1 over to P7, and sit AV1 down. P7 did not think the SP should be "grabbing" and "dragging" a child like that. P7 stated that P2 had expressed to all of the staff persons that AV1 had had a medical procedure and to be careful when moving AV1. At the time, P7 did not see any marks on AV1's arms, but P2 showed P7 photos that showed a red hand mark on AV1's arm as if it was held too tightly. P7 said s/he would not feel comfortable having the SP watch a child of his/her own. P7 stated that P2 brought this incident to P1 and P1 made it seem like P2 was a bad coworker. P7 said staff persons were scared and had a "fear of saying anything" because of what might happen to them.

- P6 stated that s/he focused on the children in his/her classroom (Blue toddler) but heard the staff persons in the Green toddler classroom be "loud and intimidating" and they were "strict" with the children. P6 had not witnessed any staff person "manhandle" a child but stated that the staff persons in the Green toddler classroom were not as focused on the children in their classroom as they should be.

- P4 stated that the SP had a "stern way" of managing the classroom and had high expectations of the children. P4 felt the SP's tone with children was "harsh."

P1 provided the following information:

- On either April 16 or 17, 2024, P2 told P1 that s/he did not "feel comfortable" with the staff in AV1's classroom and that AV1 had a mark on his/her arm from a staff person. The next day FM1 came to the facility to talk to P1 and his/her supervisors.

- P1 opened an investigation and watched a video and saw AV1 on a tricycle and s/he pushed another child. The SP was on his/her telephone and went and "grab[ed]" AV1 from the tricycle and put him/her to the side (of the gym) with another staff person. P1 said P2 was in the bathroom and only came back and saw AV1 crying. P1 had the SP, P3, and P5 write up statements and they said they did not see "anything out of the normal."

- P1 communicated with FM1 that the facility did not "find any maltreatment." P1 stated that FM1 brought up another incident that happened in the bathroom with AV1, but FM1 said P2 talked directly to the staff person involved in that incident, so that was why FM1 did not talk to P1 about it prior.

- P1 had no prior concerns with the SP.

- After P1's initial interview, on June 3, 2024, this investigator showed P1 video footage from March 28, 2024, and P1 gasped at the incidents s/he was shown. In a letter sent to this investigator on June 10,

2024, P1 stated, "The behavior seen in the video was unacceptable for staff [persons] working in our program."

The facility's *Behavior Guidance Policy* found in the *Parent Handbook, Policies, and Procedures* stated, "At no time and under no circumstance will punishment that is humiliating or frightening be used on a child. This includes, but is not limited to hitting, slapping, shaking, striking with an object, pinching, or inflicting any other form of corporal punishment."

Facility records showed that the SP and P1-P8 were each trained on the facility's *Behavior Guidance Policy* and the Reporting of Maltreatment of Minors Act.

Relevant Rule and/or Statute

Minnesota Rules, part 9503.0055, subpart 1, item A, states that facilities must ensure that each child is provided with a positive model of acceptable behavior.

Minnesota Rules, part 9503.0055, subpart 3, item A, prohibits the use of corporal punishment including but not limited to (in part), rough handling, shoving, kicking, slapping, hitting, and shaking.

Conclusion:

A. Maltreatment:

P2 stated that on March 28, 2024, s/he was working in the Blue toddler classroom and heard AV1 scream from the Green toddler classroom. P2 looked in the Green toddler classroom and saw the SP pull and shake AV1 while screaming at AV1 to "calm down." P2 told the SP it was not okay to pull AV1 like that, and the SP told P2 s/he was "frustrated." P2 also spoke with P1 about the incident. Video footage from March 28, 2024, showed the SP pull two children who were seated on the floor (AV5 and AV8) up by their wrists to a standing position; hit AV2 on the back while AV2 was playing with tambourines; hit AV6 in the head after AV6 threw a toy toward a bucket and missed; swat at AV8's hands and AV7's hands; pull on the back of AV2's shirt hard enough that AV2 started to fall sideways off a chair; grab several children (AV2, AV3, and AV9) and push or pull them into a position the SP wanted them to be in; use his/her foot to kick AV4's foot so AV4 would put toys in a bucket for cleanup time; and use his/her foot to push in a chair AV1 was seated in (AV1 was jostled by the motion). After reviewing the video from March 28, 2024, with this investigator, P1 sent a letter to this investigator stating that the behavior on the video was "unacceptable" for staff persons working at the facility.

P2 stated that on April 16, 2024, the Blue and Green toddler classes were in the gym. P2 returned from the bathroom and saw the SP "grab and pull" AV1 off of a tricycle and bring AV1 to another staff person. Video footage from April 16, 2024, showed the SP take AV1 off of a tricycle by AV1's wrist and AV1 and the SP started to walk. AV1 fell to his/her knees, and the SP bent over and picked AV1 up by his/her upper arms and carried AV1 to another staff person who was just out of view of the video footage. P2 and FM1 each saw marks on AV1's upper arms on April 16, 2024.

P3 stated that on an unknown date, AV2 was crying and P8 told P3 that the SP pushed AV2 into a table and AV2 hit his/her stomach. P3 witnessed the SP "aggressively" grab children and set them down. On an unknown date, P7 said the Green and Blue toddler classes were in the gym, and P7 saw the SP lift AV1 by his/her arm and pull

AV1 over to P7 and sit AV1 down (possibly the same incident captured in the video footage from April 16, 2024). P7 did not think the SP should be "grabbing" and "dragging" a child like that. P6 stated that the staff persons in the Green toddler classroom were "strict" and P4 said the SP's tone of voice was "harsh." Although FM9 said that AV9 came home from the facility with bruises, it was unknown whether the bruises were caused by the SP. There was no other information that AV2 – AV9 were injured as a result of the SP's conduct.

The SP stated s/he had a "strong" voice and would grab a child under the arms if s/he needed to be moved but the SP stated s/he did not drag, grab, or shake a child "by intention." The SP denied leaving marks on a child. The SP denied hitting a child and stated that was "totally false." The SP also denied striking, swatting, tapping, popping, or smacking a child, even after this investigator told the SP there was video footage showing s/he did.

Although the SP denied hitting a child or intentionally grabbing a child, given that P2, P3, and P7 witnessed the SP grab and pull children; and that video footage showed the SP pulling children from a seated to standing position, hitting children, grabbing children and pushing or pulling the children to sit them down; and that AV1 sustained a transitory red mark on the back of his/her left upper arm as a result of the SP's conduct; there was a preponderance of the evidence that the SP's actions represented a pattern of threatened injury to children in his/her care.

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).

In addition, there was a preponderance of the evidence that the SP's actions represented a failure to supply AV1-AV9 with reasonable and necessary care and a failure to protect AV1-AV9 from conditions or actions that seriously endangered AV1's-AV9'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 reasonable 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.

The SP was trained on the facility's *Behavior Guidance Policy* and the Reporting of Maltreatment of Minors Act and was responsible for the care of AV1 – AV9 as a staff person working at the facility. The SP was responsible for maltreatment of AV1 – AV9.

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 abuse and neglect for which the SP was responsible did not meet statutory criteria to be determined as recurring or serious. The SP's conduct toward AV1 – AV9 was considered a single pattern of behavior. Although AV1 had a red mark on his/her arm resulting from the April 16, 2024,

incident, the mark was transitory in nature and there was no conclusive information that AV2 – AV9 sustained injuries as a result of the SP's physical abuse and neglect.

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 policies were not followed by the SP. The SP no longer worked at the facility and the other staff persons were retrained on the facility's *Behavior Guidance Policy*.

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

The SP was not disqualified from providing direct care services as a result of the maltreatment determination in this report. However, the SP was 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 the disqualification of the SP. The determination that the SP was responsible for maltreatment is subject to appeal.

Minnesota Statutes, section 260E.06, subdivision 1, requires mandated reporters at a facility to immediately report suspected maltreatment. The investigation determined that five individuals failed to report suspected maltreatment as required. A letter from DHS was sent to each of these individuals regarding their failure to report the suspected maltreatment and potential consequences for future such failures.

On October 4, 2024, the facility was issued a Correction Order for the violations outlined in this report. In addition, it was determined that facility mandated reporters, including one mandated reporter in a management role had knowledge of the alleged incident and did not report the incident as required. The license holder was ordered to forfeit a fine of $200 for failure to report maltreatment. The Order to Forfeit a Fine is subject to appeal.

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.