

**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:** 202407080

**Date Issued:** October 31, 2024

**Name and Address of Facility Investigated:**

New Horizon Academy  
2385 Rosemary Way  
Lino Lakes, MN 55038

**Disposition:** Maltreatment determined as to neglect of an alleged victim by a staff person. A nonmaltreatment mistake to an alleged victim by another staff persons was not maltreatment.

**License Number and Program Type:**

1109757-CCC (Child Care Center)

**Investigator(s):**

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**Suspected Maltreatment Reported:**

It was reported that an alleged victim (AV) was unsupervised in his/her classroom for approximately five minutes.

**Date of Incident(s):** August 13, 2024

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

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

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

**Summary of Findings:**

Pertinent information was obtained during a site visit conducted on September 5, 2024; from documentation at the facility; and through seven interviews conducted with the AV, a facility supervisory staff person (P1), four staff persons (P2, P3, SP1, and SP2), and the AV's family member (FM).

The AV was approximately four and a half years old and enrolled in one of the facility's preschool classrooms at the time of the incident. The AV's classroom had two bathrooms, each with a half door. The classroom also had an exterior door that led to an enclosed playground. In addition, there were two doors that led to nearby preschool rooms and a main classroom door that led to a large motor room and other areas of the facility. The classroom had lockers for children to store their belongings in.

The *Name to Face Attendance Form*, the *Daily Attendance*, and untitled staff schedule showed that on August 13, 2024, at the time of the incident, there were 19 children in the classroom, including the AV. SP1 and SP2 worked in the AV's classroom.

P2 and P3 provided the following information:

- On an unknown date, later determined to be August 13, 2024, P2 and P3 walked into the AV's classroom on their way to an adjoining room, when they found the AV unsupervised. P2 thought the incident occurred between 10 and 11 a.m. and P3 thought it occurred between 8 and 9 a.m. P2 and P3 asked the AV where his/her class was, and the AV said that s/he "went to the bathroom last minute" and that his/her class "left and went to the bounce house." The AV was crying, "confused," and "upset" because s/he wanted to go on the bounce house with the rest of his/her class. The AV was not injured.
- P3 then returned the AV to his/her class, who was outside on the bounce house. P3 asked SP1 and SP2 why the AV was "left" in the classroom, and SP1 became "teary eyed" and said that they "did something wrong." SP1 told P3 that s/he did a name to face count using the iPad when s/he took the children out of the room. SP1 "knew" that the AV was in the classroom but said that the AV had not been "clocked in" on the iPad so when SP1 counted, s/he "missed" the AV. P3 then told P1 about the incident.
- P2 said the AV was unsupervised for "no more" than five minutes because the AV's class had just gone outside. P3 said the AV was unsupervised for five or six minutes because prior to P2 and P3 finding the AV, P3 "watched" SP1, SP2, and the children using a walking rope to walk past P3 on the way to the bounce house.
- Staff persons were trained to check the bathrooms and other areas where children could "hide," prior to leaving the classroom. Staff persons were also trained to line children up, do a name to face count, and use the walking rope prior to leaving the classroom. P3 said that the parents of children were supposed to "clock" their children in on an iPad each morning but if a parent did not do so, then it was staff persons "responsibility" to add them.
- P2 and P3 worked with SP1 and SP2 prior and had no concerns regarding their supervision of children and said that typically, they did as they were trained to do. SP1 also typically checked the bathrooms prior to leaving the room.

The AV told this investigator that at some point, s/he was in the bathroom when SP1 and SP2 took his/her class

outside to the bounce house. SP1 and SP2 did not know that the AV was in the bathroom when they left. P2 and P3 found the AV and returned the AV outside to the bounce house where the AV was able to play. When this investigator asked the AV how s/he felt about the incident, the AV said, "I don't know."

P1 and an untitled document from the facility provided the following consistent information:

- On August 13, 2024, around 9:40 a.m., P3 told P1 that P2 and P3 found the AV unsupervised in his/her classroom. P3 said that s/he then brought the AV outside where his/her class was playing in the bounce house.
- Once P1 became aware of the incident, s/he spoke to SP1 and SP2. SP1 and SP2 said that at the time of the incident, the children lined up using the walking rope. SP1 looked at a list of the children's names using the iPad and put his/her hand on each child to count them. SP1 and SP2 were each at one end of the line of children, which they were trained to do. However, SP1 said that s/he typically checked the bathrooms prior to leaving the classroom but did not do so on the date of the incident. Staff persons were also trained to count the children once they got outside but P1 did not know if SP1 and SP2 did so.
- P1 reviewed video footage from the incident which corroborated what SP1 and SP2 told him/her, including SP1 counting, using the walking rope, and SP1 and SP2 each at one end of the line. The footage showed that after the class left, the AV came out of the bathroom and began reading a book in the "book nook." The AV was unsupervised for approximately five minutes. There were no injuries to the AV and P1 "could not see" from the video footage if the AV was crying.
- The AV's classroom was age appropriate to the AV and P1 was not aware of any risks to the AV from being unsupervised in the classroom. However, the AV could have exited the classroom through one of the four classroom doors.
- At the time of the incident, the AV was not signed in on the iPad by his/her parents which caused "confusion." Additionally, another child was dropped off while the AV was in the bathroom, which "unfortunately threw off the count process."
- Both SP1 and SP2 were responsible for the supervision of the AV at the time of the incident. P1 had no prior concerns with SP1 and SP2, including regarding supervision.

SP1 provided the following information:

- On August 13, 2024, around 10 a.m., SP1 and SP2 worked in the AV's classroom and the children were finishing a worksheet. A parent dropped off a child and then the class began getting ready to go to the bounce house outside including children putting their worksheets in their locker. SP1 began getting children in a line to hold onto the walking rope. During this, some of the children were pushing or needed SP1's "attention," so SP1's "attention was divided" between assisting children with "reminders to use gentle hands" and getting them in line. SP1 described it as a "little chaotic." SP1 looked at the iPad and saw there were 17 children signed in for the day and SP1 counted 17 children, so SP1, SP2, and the children left the classroom. SP1 did another count as the children passed through the large motor room and once they got outside. They had "just" gotten outside when P3 brought the AV outside. The AV was a "little sad" so "cuddled" with SP2 "for a minute" and then played in the bounce house. SP1 thought that the AV was unsupervised for one or two minutes because they had just gotten outside when P3

returned the AV.

- SP1 did not see the AV going to use the bathroom but said that typically, the AV notified staff persons prior to doing so. However, the AV did not do so at the time of the incident.
- There were no injuries to the AV from being unsupervised. However, the AV could have left the classroom and entered another part of the building.
- The AV was not signed in on the iPad on the morning of the incident, so the classroom iPad count was off. Parents typically signed their children in when they arrived, but the AV's parents did not do so on the date of the incident. Because the AV had not been signed in, SP1 did not know what time the AV arrived. Both SP1 and SP2 were responsible for the supervision of the AV at the time of the incident.

SP2 provided the following information:

- On an unknown date in August 2024, SP2 worked with SP1 in the AV's classroom. Between 10 and 11 a.m., the children got ready to go outside to the bounce house. SP1 had the iPad which showed there were 18 children in the classroom so SP2 counted the children and had 18. SP1 had the children line up using the walking rope and did a "name to face count." SP1 and SP2 did not check the bathroom, prior to leaving the classroom, which staff persons were trained to do. Then they left the room with the children, did another count, and entered the bounce house area.
- Approximately three to five minutes later, when the children were playing in the bounce house, P3 came outside with the AV. SP1 and SP2 were not aware that the AV was left in the classroom. SP1 and SP2 "comforted" the AV who had "tears in [his/her] eyes." The AV said that s/he was "upset because [s/he] got left" and said that s/he was by him/herself for "six hours." The AV initially did not want to go in the bounce house so SP2 sat by the AV and talked with him/her until s/he went to play.
- Although the AV was not injured, risks to the AV being unsupervised included the AV falling in the classroom or getting hurt.
- At the time of the incident, there were 19, not 18, children in the classroom, but the FM "forgot" to sign the AV in that morning and SP1 and SP2 did not realize that the AV was not signed in. When a parent forgot to sign their child in, staff persons were supposed to add the child to the list on the iPad. Because the AV had not been signed in, SP2 did not know what time the AV arrived that day but was aware the AV had arrived to the facility. The AV typically arrived between 8:30 and 9:30 a.m.
- Following the incident, SP2 viewed video footage of the incident and saw that after the AV completed his/her worksheet, the AV went to the bathroom, which SP1 and SP2 did not see. The AV typically told staff persons that s/he was going to the bathroom but did not do so on the date of the incident.

Video footage of the AV's classroom showed that at 9:37:25 a.m., the children, including the AV, were sitting at tables with SP1 and SP2. At 9:37:30 a.m., a parent dropped off another child. SP1 then grabbed the walking rope and children began lining up near the door while holding onto the walking rope. During this, at 09:40:10 a.m., the AV went into the bathroom. SP1 was at the front of the line and counted children by walking down the line and touching or pointing near their heads. SP1 was also holding and looking at an iPad. SP1 then opened the main classroom door and counted the children's heads a second time as they walked through. SP2 was at the back of

the line and at 09:41:30 a.m., the classroom door automatically closed after they left the room. At 09:41:50 a.m., the AV looked out the half wall of the bathroom but then returned into the bathroom and was out of the camera view. At 09:43:20 a.m., the AV walked out of the bathroom and appeared to be crying. The AV sat on a couch in the room and picked up a book. At 09:46:25 a.m., P2 and P3 came into the classroom, looked at the AV, appeared to look around the room, and then went to the AV. At 9:46:49 a.m., P2 and P3 walked with the AV out of the classroom into the large motor room, which had another class playing in it. Video footage from outside showed that at 9:47:50 a.m., the AV was returned to his/her class, who were playing in the bounce house.

The FM said that P1 notified him/her of the incident on the date it occurred and that the AV was unsupervised about five minutes in his/her classroom. The AV was "fine" and reading a book. The FM spoke to the AV about the incident who said that s/he was "screaming and crying" when s/he was alone. There were no injuries to the AV. The FM had no prior concerns with the facility.

The *Safety and Supervision Policies* said that staff persons were to "never" leave children unattended for any reason. Children were to be within sight and sound of staff persons at all times. The *Transition Policy* said that when transitioning, the walking ropes "must" be used. The children were to line up "on" the rope and staff persons were to count the children via a name to face count. Staff persons were to do a "sweep" of the classroom prior to leaving. When the class got to where they were going, staff persons were to count the children again via a name to face count.

The *Risk Assessment and Risk Reduction Plan* said that preschoolers could use the bathroom independently, but staff were to "monitor" the children when in the bathroom. Staff persons were to always be within sight and sound of children. When children were transitioned from one area to another, children were to form a line using a walking rope. Staff persons were to call the children by name to hold onto the walking rope and were to use a name to face count. One staff was to be at the front of the line and the other at the back.

Facility documentation showed that SP1, SP2, P1, P2, P3 each received training on the Maltreatment of Minors Reporting Act and on the facility's policies including the Risk Reduction Plan, the Transition Policy, and the Safety and Supervision Policy.

#### *Relevant Rules and Statutes:*

Minnesota Statutes, section 245A.02, subdivision 18 and Minnesota Rules, part 9503.0045, subpart 1, item A, state that "supervision" means 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; and that children are required to be supervised at all times.

#### **Conclusion:**

Information was consistent that on August 13, 2024, around 9:40 a.m., the AV was in his/her classroom for approximately five minutes without the knowledge or supervision of SP1 or SP2 which was a violation of Minnesota Statutes, section 245A.02, subdivision 18, and Minnesota Rules, part 9503.0045, subpart 1, item A.

SP1 stated that around 10 a.m., SP1 and SP2 worked in the AV's classroom and the children were finishing a worksheet. A parent dropped off a child and then the class began getting ready to go to the bounce house outside including children putting their worksheets in their locker. SP1 began getting children in a line to hold onto the walking rope. During this, some of the children were pushing or needed SP1's "attention," so SP1's "attention was divided" between assisting children with "reminders to use gentle hands" and getting them in line.

SP1 described it as a "little chaotic." SP1 looked at the iPad and saw there were 17 children signed in for the day and SP1 counted 17 children, so SP1, SP2, and the children left the classroom. SP1 did another count as the children passed through the large motor room and once they got outside. They had "just" gotten outside when P3 brought the AV outside.

SP2 stated that between 10 and 11 a.m., the children got ready to go outside to the bounce house. SP1 had the iPad which showed there were 18 children in the classroom so SP2 counted the children and had 18. SP1 had the children line up using the walking rope and did a "name to face count." SP1 and SP2 did not check the bathroom, prior to leaving the classroom, which staff persons were trained to do. Then they left the room with the children, did another count, and entered the bounce house area. Approximately three to five minutes later, when the children were playing in the bounce house, P3 came outside with the AV. SP1 and SP2 were not aware that the AV was left in the classroom because the AV had not been signed in for the day.

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.

*Regarding SP2:*

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

- (1) SP2 counted the children prior to leaving the classroom, on the way to the bounce house, and once they were at the bounce house. However, SP2 had the incorrect count because the AV was not on the list.
- (2) SP2 has not previously been found responsible for a similar incident that resulted in a finding of maltreatment or a nonmaltreatment mistake in the past.
- (3) SP2 has 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 and SP2 were in compliance with all relevant licensing requirements.

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

*Regarding SP1:*

A. Maltreatment:

Although SP1 was performing job related duties at the time of the incident including counting the children, the AV was not injured, and the facility and SP1 were in compliance with all licensing requirements relevant to the incident, SP1 had been determined responsible for a similar incident that resulted in a finding of a non-maltreatment mistake. Therefore, SP1 was not able to be considered under a non-maltreatment mistake for this report.

The AV was in a classroom designed for children who were the AV's age, however, the AV was unsupervised for approximately five minutes. The AV was found by P2 and P3 who brought the AV to SP1 and SP2, who were outside on the bounce house. Given that the AV was four and a half years old, it was unlikely that the AV would be able to provide for him/herself in an emergency and staff persons were not aware that the AV was in the room in the event of an emergency. Therefore, there was a preponderance of the evidence that there was a failure to supply the AV with the necessary care and a failure to protect the AV from conditions or actions that could seriously endanger the AV's physical or mental health.

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.

SP1 and SP2 were trained on the Reporting of Maltreatment of Minors Act and on the facility's policies including the Risk Reduction Plan, the Transition Policy, and the Safety and Supervision Policy, prior to the incident.

At the time of the incident, SP1 and SP2 were responsible for the supervision of the children, including the AV. However, given that SP2's conduct met the requirements for a non-maltreatment mistake, SP2 was not responsible for maltreatment of the AV.

SP1 did not meet the requirements for a non-maltreatment mistake, therefore SP1 was responsible for the 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 was responsible did not meet statutory criteria to be determined as recurring or serious. It was a single incident and SP1's previous determination of non-maltreatment mistake was not maltreatment and the AV did not sustain a serious injury that required the care of a physician.

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. This included SP1 and SP2 not having an "accurate" count of the children in their classroom and not doing a walk through of their classroom. Following the incident, the facility revised their supervision policies, which staff persons were retrained on. This included updating the "tracking pattern" of children.

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

SP1 was not disqualified from providing direct care services as a result of the maltreatment determination in this report. However, SP1 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 disqualification. The determination that SP1 was responsible for maltreatment is subject to appeal.

SP2 was not determined as a perpetrator of maltreatment of the AV because the Department of Human Services found that the incident for which SP2 was responsible met the criteria to be determined a nonmaltreatment mistake. SP2 was notified by the Office of Inspector General that any future incident of possible neglect of an alleged victim for which SP2 is responsible might not be considered a nonmaltreatment mistake.

On October 31, 2024, the facility was issued a Correction Order for the violation 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.