

**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:** 202409318

**Date Issued:** December 26, 2024

**Name and Address of Facility Investigated:**

KinderCare Learning Center  
4732 Excelsior Boulevard  
Saint Louis Park, MN 55416

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

**License Number and Program Type:**

1025410-CCC (Child Care Center)

**Investigator(s):**

Beth Virden  
Minnesota Department of Human Services  
Office of Inspector General, Licensing Division  
PO Box 64242  
Saint Paul, Minnesota 55164-0242  
beth.virden@state.mn.us  
651-431-6572

**Suspected Maltreatment Reported:**

It was reported that an alleged victim (AV) was left in a classroom for 10 to 40 minutes without the knowledge and/or supervision of a staff person. The AV was not injured.

**Date of Incident(s):** July 31, 2024; received by the Department of Human Services on October 28, 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 November 7, 2024; from documentation at the facility; and through interviews conducted with facility staff persons (SP1, SP2, and P1), and a supervisory staff person (P2). Attempts by phone and mail to contact the AV's family member (FM) were not responded to by the completion of the investigation.

At the time of the incident, the AV was 17 months old and enrolled in the facility's toddler classroom.

The facility provided childcare to various age groups in more than one classroom. There was a playground along the back of the building. The toddler classroom faced the front of the building. To access the playground, the toddler classroom needed to enter a hallway, and walk about 10-20 feet to a shorter hallway, which headed toward the back of the building. There were two doors in this hallway before it opened to the outdoor space. The facility did not have cameras.

SP1, SP2, and facility's *Classroom Supervision Record* (classroom roster) provided the following information:

- On July 31, 2024, SP1 and SP2 were working in the toddler classroom with 11 children, including the AV. SP1 and SP2 were not the "regular teachers" for that classroom but were substitutes that day.
- SP1 said that around 3 p.m., after naptime, the classroom was preparing to go to the playground. The children lined up at the door. SP2 was carrying the classroom roster on a clipboard. SP1 believed SP2 completed a name to face count and asked SP2, "Do we have everyone," and SP2 said, "Yes." SP2 led the children into the hallway and SP1 followed at the back of the line. SP1 glanced around the classroom before leaving and did not see anyone left behind.
- SP2 said that before going into the hallway, s/he called each child's name and watched the child walk through the threshold into the hallway, and then "marked" that child on the roster. When SP2 called the AV's name, a child walked out but SP2 did not look at the child to ensure it was the AV. Once everyone was in the hallway, SP2 believed they had everyone. SP1 checked the classroom and did not see anyone left behind. The group then walked to the door leading outside, where SP2 counted again and realized, "We were off by one." SP2 looked at the children and determined the AV was missing. In response, the entire group walked back to the classroom where they found the AV playing in a sink of water. SP2 believed the AV was unsupervised for five minutes.
- However, according to SP1, they went outside without noticing the AV was missing and remained there for about 20 to 30 minutes. "The whole time we didn't notice [the AV] was missing." "We didn't do a name to face (count) while we were out there." They discovered the AV missing when they returned to the classroom, around 3:30 or 3:40 p.m., and saw the AV "still in there." "We realized we left [the AV] during that whole time." The AV was playing with toys and "seemed fine."
- SP1 did not tell anyone (e.g., a supervisor) about what happened. SP1 explained, "[The AV] was here and safe ... We left it at that ... See if it blows over ... See if someone says something."
- SP2 said that s/he talked to P2 about the incident but could not recall when this conversation took place, whether the next day or sometime after.
- SP1 and SP2 each said that when transitioning the toddler classroom to the playground, staff were

supposed to have the children line up by the classroom door and complete a name to face count that included calling each child's name, waiting for that child to answer, looking at that child, and then marking them as present on the classroom roster. The children were then led into the hallway where staff again counted them. Once they were outside, staff counted again. This process was completed in reverse on the way in.

- SP1 did not count the children during the incident timeframe and explained, "I trusted (SP2's count) I guess, instead of actually looking myself ... I assumed we had everyone. At the time we were walking outside, I didn't think about it."
- SP2 said that s/he "vividly" remembered marking the classroom roster with the name to face count on the way to the playground. [Note: The classroom roster did not show any markings beyond 12 p.m., that day., which was also the time the "regular" teacher left for the day, leaving SP1 and SP2 in charge.] SP2 did not know why the roster was blank but said that it was possible they used two rosters that day if there was a mistake on one.
- SP2 added that the information about the AV being left in the classroom for longer than five minutes was not true. According to SP2, this information came from three staff, who wanted to get SP2 fired. SP2 named the staff and SP1 was not one of them.

P1 provided the following information:

- On July 31, 2024, P1 helped clean the toddler classroom at the end of the day and during this time, SP1 and SP2 told him/her that they left the AV inside when they went outside to the playground. P1 could not recall the details but said that SP1 and SP2 were discussing "whose fault it was."
- P1 was trained to complete a name to face count as the children lined up at the classroom door. Staff called each child's name and put a check mark next to that child's name on the roster. The group then walked into the hallway where they "did the same thing." Then, when they approached the exit to the playground, staff called each child's name again as they walked out the door. Staff were not required to count while they were on the playground. "Just when we go out and come back in."

P2 provided the following information:

- On the day of the incident, P2 was not told about the incident. Later that day, P2 saw SP1 at a personal event and asked how the day went. SP1 did not mention leaving the AV in the classroom. "It never came up." Then on August 15, 2024, P1 and P2 were chatting about P1's career aspirations. When the AV's name came up in conversation, P1 said something like, "Remember when that happened (the AV left in the classroom)? That was crazy, right?" P2 immediately asked, "What?" P1 explained, "Remember when [the AV] was left alone in the classroom?" P2 had no idea what P1 was talking about. "No one told me." P2 immediately texted his/her assistant, who had been in charge at the time of the incident on July 31, 2024; however, the assistant was also not informed and had no knowledge.
- On August 16, 2024, P2 interviewed SP1 and SP2. SP1 and SP2 each told P2 that they did not count the children when they left the classroom or at any other points during the transition. SP1 told P2 that the AV was alone in the classroom for 35 to 45 minutes, or "the entire time they were outside." SP2 provided conflicting information to P2 and said that the AV was alone for 5 to 10 minutes but also said that s/he

noticed the AV was missing as soon as they arrived outside and ran back inside but was stopped by a parent. SP2 then walked with that parent back outside and afterward went back inside for the AV. P2 asked SP2 why no one told him/her and SP2 said, "We figured it out."

- P2 added that when the toddler classroom went outside on July 31, 2024, the classroom lights would have been turned off. The AV was then playing with toys in a darkened room. P2 said that the AV was not injured or crying when the staff discovered him/her.
- P2 said that on May 31, 2024, all staff, including SP1 and SP2, were trained on the facility's newest initiative called, "One foot in, one foot out," which regarded transitions and counts. Staff were instructed to call each child's name and watch that child pass through each threshold before moving onto the next threshold. During this training, some staff, including SP2, demonstrated or practiced the "one foot in, one foot out" procedure for the rest of the staff.
- P2 did not have prior concerns with SP1's and/or SP2's conduct.

The facility's *Child Supervision Record (Name to Face Attendance)* procedure stated the following:

- Staff ensured children were always safe, supervised, and accounted for.
- Staff were required to always carry their classroom roster with them.
- A name to face procedure of all children should be completed every time the classroom moved from one room to the next, or from indoors to outdoors, or from outdoors to indoors. A name to face procedure should be completed when returning to the classroom. Counting the children instead of a name to face procedure was not permitted.

Facility documentation stated that SP1, SP2, P1, and P2 received training on the facility's *Child Supervision Record* and the Reporting of Maltreatment of Minors Act.

#### *Relevant Minnesota Statutes and Rules:*

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 31, 2024, the AV was left unsupervised in a classroom for between 5 and 45 minutes, which was inconsistent with the facility's *Child Supervision Record* procedure; and a violation of Minnesota Statutes, section 245A.02, subdivision 18, and Minnesota Rules, part 9503.0045, subpart 1, item A.

SP1 did not count the children as they transitioned on July 31, 2024. SP1 believed SP2 was counting and asked

him/her if they had everyone, to which, SP2 said, "Yes." However, they did not, and the AV was left in the classroom, unsupervised, for 20 to 30 minutes. "The whole time (outside) we didn't notice [the AV] was missing." Staff discovered the AV "still there" in the classroom when they returned inside.

SP2 said that s/he counted the children as they left the classroom but did not specifically look if the AV was the one who went into the hallway when the AV's name was called. SP2 said that s/he counted again prior to going outside and noticed at that time, the AV was missing. In response, the whole group returned and retrieved the AV. SP2 said that the AV was unsupervised for 5 to 10 minutes.

Given that SP2 provided different information during his/her interview and to P2; that the class roster showed that SP2 did not mark the class roster as s/he said; that SP2 thought that the conflicting information about what happened came from three specific staff, which did not include SP1; and that SP1's account remained consistent, including matching P2's account of when P2 found out about the incident, it was more likely that SP1's account of the incident was more accurate and that the AV was left unsupervised "the entire time" the class was on the playground and that SP1 and SP2 did not know the AV was missing until they returned 20 to 30 minutes later.

The AV was 17 months old, and 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 classroom in the event of an emergency. Therefore, there was a preponderance of the evidence that there was a failure to supply the AV with necessary care and a failure to protect the AV from conditions or actions that seriously endangered his/her health and safety.

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 received training on the facility's *Child Supervision Record* and the Reporting of Maltreatment of Minors Act. SP1 and SP2 were responsible for the care and supervision of the AV at the time of the incident.

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 and/or serious. SP1 and SP2 were responsible for a single incident of which 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 the policies and procedures were adequate but not followed. The facility provided additional training to staff regarding name to face counts and transitions. SP2 was no longer employed.

**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 December 26, 2024, the facility was issued a Correction Order for the violation outlined in this report.

In addition, it was determined that facility mandated reporters 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.

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

**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.