

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: 202404071

Date Issued: January 30, 2025

Name and Address of Facility Investigated:

Temple Israel Early Childhood Center
2323 Femont Avenue South
Minneapolis, MN 55405

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

License Number and Program Type:

802471-CCC (Child Care Center)

Investigator(s):

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Suspected Maltreatment Reported:

It was reported that an alleged victim (AV) was in an activity room without staff persons' supervision or knowledge for approximately three minutes.

Date of Incident(s): May 10, 2024

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

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

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

Summary of Findings:

Pertinent information was obtained during a site visit conducted on May 20, 2024; from documentation at the facility; and through four interviews conducted with one supervisory staff person (P), and three facility staff persons (SP1, SP2, SP3). An attempt to contact the AV's family member by telephone was unsuccessful.

Facility documentation showed the AV was 31 months old at the time of the incident and enrolled in the facility's toddler classroom.

The facility was located in a synagogue but separated from that area by secured doors. Beyond the secured doors was a main hallway. Off the main hallway were classrooms and other hallways that led to more classrooms, restrooms, and a playground. At one end of the main hallway were the facility offices and classrooms including the AV's classroom. At the other end of the hallway was an activity room. The activity room was a large open space with climbing and riding toys. The activity room had two exit doors, one to the main hallway, and one to a smaller hallway off the main hallway. The outside of the activity room doors were locked and opened with a key. The inside of the doors had child safety locks. This investigator had the AV attempt to open an activity room door from the inside and the AV was unable to open the door. There was a large window between the activity room and the main hallway. The facility had two video cameras. One camera was located in the small hallway near the activity room door and the other camera was located in the main hallway near the activity room.

The P and the facility's *Incident Report* provided the following consistent information:

- On May 10, 2024, the P was not at the facility when s/he received a text message from a staff person who said that a child had been unsupervised. The P then went to the facility and talked with SP1, SP2, and SP3.
- SP1 told the P that they followed their routine of cleaning the activity room before leaving but that neither SP1, SP2, nor SP3 counted the children before leaving the room.
- SP2 told the P that s/he went out and sat on a rug outside the activity room and did not count the children until they were in the toddler classroom.
- SP3 told the P that s/he did not count the children before or after they left the activity room. Once the group was in the toddler classroom, SP2 counted eight children, but there should be nine children so s/he "ran" back to the activity room and found the AV under the climber.
- The P reviewed video footage of the incident and the footage showed the toddler classroom was in the activity room from 11:12 to 11:40 a.m. The small hallway activity room door shut at 11:40:45 a.m. The class walked down the main hallway to the toddler classroom. At 11:42 a.m., SP3 left the toddler classroom, walked down the main hallway, and entered the activity room at 11:43:15 a.m. Then SP3 and the AV left the activity room at 11:43:40 a.m. and walked back to the classroom. In the classroom, SP1, SP2, and SP3 counted eight children and "knew" there should be nine children so SP3 "ran" back to the activity room and found the AV. The AV was unsupervised for two minutes and thirty seconds.

SP1, SP2, and SP3 provided the following information:

- On May 10, 2024, SP1, SP2, SP3, and nine children, including the AV, were in the activity room. When it was time to go to their classroom, SP2 told SP1 that s/he was going to go into the hallway and sit on the carpet with the children.
- SP1 was by the activity room door and SP3 was inside the activity room. SP2 "counted five" children, none of which was the AV, and took them out to the hallway.
- SP3 told SP1 that the rest of the children in the activity room were cleaning up. SP1 told SP3 s/he was going to go into the hallway and then SP1 went into the hallway. SP1 then told SP2 s/he was going to go to the end of the hallway where it intersected with the main hallway to block children from going down the main hallway opposite the classroom. Before SP1 could move, SP2 stood up and walked down the hallway with the children. SP1 asked SP2 to wait because SP3 and the rest of the children were not yet out of the activity room. SP1 did not know if SP2 heard him/her because SP2 kept walking.
- SP3 then exited the activity room so SP2 "started moving" down the hallway. SP3 did not know how many children were in the hallway and "assumed" that SP1 and SP2 counted the children. SP1, SP2, SP3, and the children walked down the hallway to the main hallway to the classroom.
- SP2 arrived at the classroom door first and SP1 asked SP2 to "wait" to go into the room but SP2 and some children entered the room anyways. SP2 then entered the classroom with other children and saw SP3 behind him/her with a child.
- Inside the classroom, SP2 sat down and "asked the children to join" him/her and they sang a song. SP1 then helped the children gather around SP2. SP2 stated at this time s/he counted eight children. SP1 and SP3 also counted the children and determined that one child was missing. Then SP1 said the AV's name and SP3 left the classroom to find the AV.
- SP3 stated s/he "ran" to the activity room. From the hallway, SP3 looked in the activity room but initially did not see the AV, then SP3 saw the AV under the climber. SP3 "ran" into the activity room, picked up the AV, and carried the AV back to the classroom. The AV was "happy," and "laughing." SP3 estimated the AV was unsupervised for two minutes or "less."
- SP1 said when the AV returned to the classroom s/he seemed "okay" and SP2 stated the AV was him/herself.
- SP1 stated that "usually" SP3 led the group out of the activity room and SP1 left the activity room last and counted the children. On the day of the incident, SP1 felt "rushed" and did not count the children until they were inside the classroom. SP1 stated that the AV was unsupervised for approximately 25 seconds. SP1 stated it took the group 15 seconds to get to the classroom from the activity room and 10 seconds for SP3 to get back down the hall. SP1 was trained to keep a "current and accurate" count of the children in his/her care.
- SP2 stated there was a "Google" list of children present on staff persons phone. Staff persons use the list to "verify numbers." SP2 had his/her cell phone and "usually" counted the children before they left the activity room, when they were in the hallway outside the activity room, at the intersection of the two

hallways, and before entering the classroom. SP2 did not “know” why s/he did not count on the day of the incident. The AV was unsupervised no more than two minutes based on the time the group left the activity room and when s/he was brought back to the classroom. SP2 was trained that children needed to be “within sight and sound at all times” and to know the number of children with SP2 “at all times.”

- SP3 stated that “normally,” s/he left the activity room first but on the day of the incident, SP2 left first with some children. SP1 and SP3 were trying to get the “last two” children out of the room. SP3 thought SP1 was the last staff person to exit. As SP3 left the activity room, s/he “expected” SP2 to wait with the children in the hallway but SP2 did not wait and started to walk down the hallway. SP3 “assumed” that SP2 counted the children. SP3 did not count the children in the hallway because they walked away. SP3 was trained that children “must” be within “sight and sound at all times.”

The facility provided three video segments of the incident. The videos were not time and/or date stamped and did not contain audio. The videos provided the following information:

- SP1 opened the activity room door and stood by it as two children walked out, followed by SP2, and another child. SP2 then walked in front of the two children and sat down in the hallway blocking the walkway. One child sat down in front of SP2 and two children stood in front of SP2. SP1 went back into the activity room and the door remained open.
- Approximately 14 seconds later, another child exited the activity room, followed by SP1, who carried a child, and another child walked behind SP1. SP1 placed the child s/he carried on the floor and stood by the door as another child walked into the hallway. Then SP1 walked away from the door and stood in the hall.
- Another child ran out of the activity room. Then SP3 exited the activity room and closed the door and the group transitioned down the hallway to the classroom. (Note: According to run time on one video, the transition down the hallways into the classroom took approximately one minute 18 seconds.)
- Approximately 18 seconds after the class went into the classroom, SP3 walked out of the classroom and ran down the main hallway toward the activity room. SP3 passed another staff person in the hallway who followed SP3 and they walked toward the activity room. That staff person pointed to the activity room window. Approximately 22 seconds after leaving the classroom, SP3 walked to the activity room door, unlocked it, and went inside, and the other staff person turned and walked down the hallway. Shortly after, the AV and SP3 walked into the main hallway from the activity room, walked down the hallway, and the video ended.

The facility’s *Risk Reduction Plan* stated that children were supervised by sight and sound at all times and staff persons were trained during orientation to count children whenever changing locations. “Staff MUST always be aware of the numbers in their groups and take a head count frequently. All teachers should be attentive to their surroundings and the students’ environment at all times. ALL staff must count the children in the group BEFORE YOU LEAVE any space, AFTER YOU LEAVE the space, and each time you ARRIVE at any space. If a staff person cannot count because they were at the back of the group and children have dispersed by the time they arrive, then upon arrival they must confirm they see each child who is signed in.”

Facility documentation showed that prior to the incident the P, SP1, SP2, and SP3 each received training on the Reporting of Maltreatment of Minors Act, and the facility’s *Risk Reduction Plan*.

Relevant Rules and/or Statutes:

Minnesota Statutes, section 245A.02, subdivision 18, and Minnesota Rules, part 9503.0045, subpart 1, item A, state 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:

Information was consistent that on May 10, 2024, the AV was in the activity room unsupervised for, according to the P, approximately two and a half minutes, which was a violation of Minnesota Statutes, section 245A.02, subdivision 18, and Minnesota Rules, part 9503.0045, subpart 1, item A.

SP1, SP2, and SP3 worked in the toddler classroom with nine children, including the AV, and were in the activity room. When the group left the activity room, the AV was left behind.

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.

Although the AV was without SP1's, SP2's, and SP3's supervision for approximately two and a half minutes it was determined that SP1's, SP2's, and SP3's actions or conduct were determined to be a nonmaltreatment mistake for the following reasons:

- (1) At the time of the incident, SP1, SP2, and SP3 were performing job-related duties and were transitioning the children from the activity room to the classroom. Although SP1, SP2, and SP3 did not count all of the children when they left the activity room, within seconds of arriving into the classroom, SP2 counted the children, they realized that the AV was missing, and 18 seconds later SP3 came out of the classroom, went to the activity room, found the AV, and brought him/her back to the classroom.

- (2) SP1, SP2, and SP3 had not previously been found responsible for a similar incident that resulted in a finding of maltreatment;
- (3) SP1, SP2, and SP3 had not previously been found responsible for a similar nonmaltreatment mistake in the past;
- (4) The AV was uninjured and did not require medical care after the incident.
- (5) Except for the period when the incident occurred, the facility and SP1, SP2, and SP3 were in compliance with all licensing requirements relevant to the incident.

The nonmaltreatment mistake to the AV by SP1, SP2, and SP3 was not maltreatment.

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

Action Taken by Facility:

The facility completed an internal review and determined that their policies and procedures were inadequate. The facility added a "final visual check" of the classroom to their supervision policy. Staff persons were retrained on the new supervision policy.

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

SP1, SP2, and SP3 were not determined as a perpetrator of maltreatment of the AV because the Department of Human Services found that the incident for which SP1, SP2, and SP3 were responsible met the criteria to be determined a nonmaltreatment mistake. SP1, SP2, and SP3 were notified by the Office of Inspector General that any future incident of possible neglect of an alleged victim for which SP1, SP2, or SP3 is responsible might not be considered a nonmaltreatment mistake.

On January 30, 2025, 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.