

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: 202408254

Date Issued: February 19, 2025

Name and Address of Facility Investigated:

Tutor Time of Blaine
1570 109th Ave
Blaine, MN 55449

Disposition: Maltreatment determined as to neglect of an alleged victim by a staff person.

License Number and Program Type:

831083-CCC (Child Care Center)

Investigator(s):

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Suspected Maltreatment Reported:

It was reported that an alleged victim (AV) was in a classroom without staff person knowledge or supervision for approximately 16 minutes.

Date of Incident(s): September 20, 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 25, 2024; from documentation at the facility; and through five interviews conducted with a supervisory staff person (P1), and four facility staff persons (SP, P2, P3, and P4). (Note: P4 was also the AV's family member).

The AV was three years old and enrolled in a preschool classroom at the time of the incident. This investigator met with the AV, but s/he did not provide relevant information pertaining to this investigation.

The facility was a stand alone building that had eleven classrooms for infants through school-age children. The facility had three playgrounds at the back of the facility separated from one another by a four-foot high chain link fence. There were two exterior doors (besides the main entrance) on the front of the building, and two exterior doors on each remaining side of the building. There were sidewalks just outside of these exterior doors that led to the back playgrounds. There was a six-foot white fence with vertical slats that surround the sidewalks and the playgrounds. There was a four-foot-high chain link gate that separated the sidewalk from the preschool playground.

The facility's *Incident Report Form* stated that on September 20, 2024, at 4:20 p.m., the AV was left unattended in the classroom for 16 minutes.

P1, P2, P3, and the SP provided consistent information that on the day of the incident, the AV was in the Early Preschool classroom (P1, P2, and P3 each stated the AV was in this classroom to maintain ratio at the end of the day). The SP was working in the Early Preschool classroom and transitioned the class outside. P3 was already outside on the playground with his/her group of children.

The SP provided the following information:

- On an unspecified date, toward the end of the day, the SP was getting a group of children ready to go outside. The SP was at the door conducting a face to name and was at the end of the list when a child (not the AV) tried to run out of the door to the sidewalk.
- Once at the gate to enter the playground the SP conducted a face to name again. P3 and his/her classroom were already outside on the playground. The SP's classroom entered the playground. As it was toward the end of the day, the SP transferred his/her list of children to P3's list to combine the classes. The SP saw the AV's name at the bottom of the list and asked P3 if s/he saw the AV, then told P3 s/he was going to go inside to look for the AV.
- The SP entered the classroom and saw the AV playing in the dramatic play area. The AV seemed "normal" but maybe a little "confused." The SP brought the AV back outside. P2 happened to come outside at that time and the SP told P2 that the AV had been left inside for what the SP thought was five minutes.
- The SP was trained to conduct a face to name by calling a child's name and having them line up along the white fence outside. Once at the gate leading to the playground, the SP was trained to conduct another face to name and place a check mark in a box on his/her list of children in the class. The SP thought that because the AV's name was at the bottom of the list that the SP "missed" seeing the AV's name.

P3 provided the following information:

- On September 20, 2024, around 4 p.m., P3 was outside with his/her class when the SP brought out his/her group of children and conducted a face to name as they entered the playground. About ten minutes later, P3 scanned the playground and asked the SP if the AV had already been picked up because P3 did not see the AV and that was when they realized the AV was not outside with them.
- The SP went inside, found the AV in the classroom, and brought the AV outside. The SP told P3 that the AV "seemed okay" and was playing in the dramatic play area.
- P3 was trained to complete a face to name by saying each child's name on his/her list of children and looking at each child as s/he moved through the door, and then to double check once at the destination to make sure everyone made it.

P2 provided the following information:

- On an unspecified date, P2 went to the playground and the SP told P2 that the AV was left in the classroom. The SP told P2 s/he thought it was for five minutes, and that the SP performed a face to name when s/he brought the class outside. The SP asked P2 to review the video. P2 told the SP s/he would let P1 know about the incident.
- P1 had already left for the day, so P2 called P1 to tell P1 what had happened. P1 had the SP go home and P2 said P1 "took care of the rest."
- P2 stated that staff persons were trained to conduct a face to name as they left a room, at every point staff persons moved children through (such as a door or gate), and at the destination.

P1 provided the following information:

- On September 20, 2024, around 4:30 p.m., P1 was at home after having left the facility for the day, when P2 called to say that the SP had left the AV in the classroom for what was thought to be five minutes.
- P1 called his/her supervisor to pull video footage and was informed that video footage showed the AV was alone for 16 minutes. P1 then called back to the facility and spoke with the SP. The SP told P1 that s/he was at the door conducting a face to name and trying to keep the children from running out of the door. The AV was at the bottom of the list and the SP must have "overlooked" the AV. P1 told the SP to go home for the rest of the day.
- On Monday, P1 spoke with P3, who said s/he witnessed the SP perform a face to name when entering the playground. When P3 went to combine his/her list of children with the SP's, s/he asked the SP if the AV had already been picked up because s/he was still on the list and that was when they realized the AV was not outside with them. P3 told P1 that the SP then went inside and brought the AV back outside. The SP told P3 that the AV seemed like his/her "normal self."
- P1 stated that staff persons were trained to complete a face to name by starting at the top of the list of

children in the class, read each child's name, watch that child exit the classroom, and place a checkmark. Staff persons were trained to double check when going through the next gate or door, and then confirm each child made it to the destination and circle the checkmark next to their name on the list.

P4 provided the following information:

- On September 20, 2024, when s/he arrived at the facility to pick up the AV around 5 p.m., P2 told P4 that the AV was left alone in the classroom. P2 did not have more information to provide to P4 but stated that P1 would talk to P4 when P1 returned to the facility.
- When P4 spoke with P1, P1 told P4 that video footage showed the AV sitting in a place that was not visible to the SP as the SP brought the children outside, and that the AV was in the classroom unsupervised for 16 minutes. P1 told P4 that the AV seemed "fine" and played in the classroom.
- P4 stated s/he was trained to perform a face to name in the classroom before a transition, and again once on the playground.

This investigator reviewed video footage of the incident, which did not have a date or time stamp, and noted the following:

- The SP stood at the doorway from the classroom to outside with a group of children by him/her. The SP had a clipboard and appeared to be conducting a face to name count. While this occurred, the AV was seated in the dramatic play area playing with dolls and was obscured from the view of the SP. The door shut and the AV leaned forward to peer toward the exterior door.
- The AV continued to sit and play in the dramatic play area and after approximately 11 minutes, an unknown person (likely another child's family member) walked into view of the camera. This person went and collected a backpack from the cubby area and then turned and walked out of view of the camera. This person was in the classroom for approximately 20 seconds.
- After the unknown person left the classroom, the AV stood up and continued to play in the dramatic play area until a person (likely the SP) was seen on the edge of the camera angle, near the interior door, motioning for the AV to come to him/her. (Note: This was approximately 16 minutes from when the SP exited the classroom, and the exterior door shut). The AV walked over to this person, and they walked out of view of the camera together.

The facility's *Face to Name Transition Sheet* for the Early Preschool classroom on September 20, 2024, showed that the Early Preschool classroom went to the playground at 4:02 p.m. The AV's name was the last on the list. In the transition box for the AV's name there was a checkmark that was circled.

The facility's *Face to Name Procedure* for transitions was:

- Line children up for the transition, confirm you have seen the child's face and said their name by putting a check mark in the row associated with their name before leaving.

- Once the child has arrived to the new location, confirm you have seen the child's face and said their name by putting a circle around the check mark.

The facility's *Child Supervision Procedure* stated, "Children must be supervised, in the direct line of sight and within earshot of a staff [person], at all times." The facility's *Risk Reduction Plan* stated, "Staff [persons] are trained on face to name procedures and direct supervision policy."

Facility documentation showed that P1, P2, P3, P4, and the SP were each trained on the facility's *Risk Reduction Plan*, the facility's *Child Supervision Procedure*, and the Reporting of Maltreatment of Minors Act.

Relevant Rule and/or Statute

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:

Consistent information was provided that on September 20, 2024, the AV was in the Early Preschool classroom with the SP and other children. When the SP brought the other children outside the AV remained seated playing in the dramatic play area. Video footage showed that the AV was without staff person supervision in the classroom for approximately 16 minutes which was a violation of Minnesota Statutes, section 245A.02, subdivision 18, and Minnesota Rules part 9503.0045, subpart 1, item A.

Although the AV did not seem bothered by the incident, given that while the AV was unsupervised in the classroom, an unidentified person (likely another child's family member) entered the classroom, and that staff persons were not there to intervene in the event of an injury or emergency, there was a preponderance of the evidence that there was a failure to supply the AV with necessary care and failure to protect the AV from conditions or actions that seriously endangered the AV's physical or mental health when reasonably able to do so.

It was determined that neglect occurred (failure by a person responsible for a child's care to supply a child with necessary food, clothing, shelter, health, medical, or other care required for the child's physical or mental health when reasonably able to do so. Failure to protect a child from conditions or actions that seriously endanger the child's physical or mental health when reasonably able to do so).

B. Responsibility pursuant to Minnesota Statutes, section 260E.30, subdivision 4, paragraph (a), clauses (1) and (2):

When determining whether the facility or individual is the responsible party, or whether both the facility and the individual are responsible for determined maltreatment in a facility, the investigating agency shall consider at least the following mitigating factors:

- (1) whether the actions of the facility or the individual caregivers were according to, and followed the terms of, an erroneous physician order, prescription, individual care plan, or directive; however, this is not a mitigating factor when the facility or caregiver was responsible for the issuance of the erroneous order, prescription, individual care plan, or directive or knew or should have known of the errors and took no reasonable measures to correct the defect before administering care;
- (2) comparative responsibility between the facility, other caregivers, and requirements placed upon an employee, including the facility's compliance with related regulatory standards and the adequacy of facility policies and procedures, facility training, an individual's participation in the training, the caregiver's supervision, and facility staffing levels and the scope of the individual employee's authority and discretion; and
- (3) whether the facility or individual followed professional standards in exercising professional judgment.

The SP stated that because the AV's name was at the bottom of the *Face to Name Transition Sheet*, the SP "missed" the AV's name. However, the AV's name had a checkmark with a circle around it for the 4:02 p.m. transition to the playground, showing that the SP incorrectly marked the AV present both when leaving the classroom and upon arrival to the playground. The SP was responsible for the supervision of the AV at the time of the incident and had received training on the facility's *Risk Reduction Plan* and the Reporting of Maltreatment of Minors Act. The SP 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 the SP was responsible did not meet statutory criteria to be determined as recurring or serious as it was a single incident, and the AV did not sustain any injuries.

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 and procedures adequate, but not followed by the SP. The SP no longer worked at the facility.

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.

On February 19, 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.