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: 202407334

Date Issued: February 19, 2025

Name and Address of Facility Investigated:

Kids Come 1st
2450 Broadway Ave N
Rochester, MN 55906

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

License Number and Program Type:

801230-CCC (Child Care Center)

Investigator(s):

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Suspected Maltreatment Reported:

It was reported that a staff person (SP) "tapped" an alleged victim (AV) on his/her head which caused the AV to fall to the side, bumped his/her mouth on a table, and caused a cut on the AV's lip.

Date of Incident(s): August 22, 2024

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

"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 a site visit conducted on September 13, 2024; from documentation at the facility; and through five interviews conducted with four staff persons (P1, P2, P3, and the SP) and the AV's family member (FM).

At the time of the incident the AV was two years old and enrolled on the toddler class.

The facility provided care for infants, toddlers, preschoolers, and school agers. The toddler classroom had three rectangular tables that were pushed together and was used for meals and table activities. Behind the table on the wall were the children's cubbies and directly across from the cubbies was the bathroom. At the end of the table near the cubbies were chairs stacked against the table when not in use.

The *Accident Report*, signed by the SP, stated that on August 22, 2024, at 11:15 a.m., "After [the AV] poured [his/her] milk out on the table. [The SP] inappropriately tapped [the AV's] head (jerk reflex) and [the AV] fell to the side bumping [his/her] mouth." The AV had a cut on the top right inside of his/her that bled. The FM was called at 3:05 p.m.

The *Incident Report*, signed by the SP, stated that on August 22, 2024, at 11:15 a.m., "One of the friends [the AV] dumped their mild out onto the table, I walked up to [him/her] and tapped the side of [his/her] head. [S/he] lost [his/her] balance and fell into a chair bumping [his/her] mouth (bit [his/her] lip).

The FM said that on August 22, 2024, between 11:30 a.m. to 12:30 p.m., s/he received voice mail from the SP stating that the AV spilled his/her milk and that the SP "inappropriately tapped" the AV on his/her head. The AV lost his/her balance, fell, and bit or hit his/her lip. When the FM picked up the AV later in the day s/he saw a "little" cut on his/her lower lip and said that the AV was "fine." The FM had no prior concerns about the SP or the facility.

P2 said that on the day of the incident s/he, P3, and the SP were sitting at the tables for lunch with six children, including the AV. The AV sat near the end of the table by the cubbies. To the right of the AV was a stack of chairs. P2 sat across the tables from the AV and the SP was to the right of the AV. The AV poured his/her milk out onto the table and the SP stood up, went to the cubbies and grabbed some paper towels. The SP then walked to the AV and "hit" the AV on the left side of his/her head with the palm of the SP's left hand. The AV fell to the right and the right side of the AV's head hit the stack of chairs. The AV began to cry, and the SP said, "I'm sorry," to the AV. The SP then picked up the AV and took the AV into the bathroom. P2 left the toddler classroom and went to the school age room and told P1 about the incident. P1 then went to the toddler classroom while P2 stayed in the school age classroom. When P2 eventually returned to the classroom, s/he did not speak with the SP or P3 about the incident, and the rest of the day was "normal." The AV had finished lunch by the time P2 returned to the classroom and P2 did not see any injuries on the AV.

P3 provided consistent information during his/her interview and in a handwritten document. P3 said that s/he and P2 were sitting at the tables for lunch with eight children, including the AV. The AV was sitting at the end of the table and there were two stacks of chairs next to him/her and the SP was standing near the AV. The AV poured out his/her milk onto the table "to be funny" and laughed. The SP walked over to the AV and "tapped" the AV on his/her forehead with his/her fingertips and told the AV while saying that was "not okay." The AV "lost [his/her] balance" and fell over to his/her right side and hit his/her face on the stack of chairs next to him/her and began to cry. The SP picked up the AV and held the AV as the AV cried. The SP looked at the AV's face, told P3 that there was blood on the AV. P3 wrote, "After [the AV] hit [his/her] lip it started bleeding." The SP then took

the AV into the bathroom to clean him/her. P2 told the SP that it was "not okay" and then left the classroom. P3 said that s/he did not see any blood on the AV. P1 came into the classroom and spoke with the SP and then left. P3 said that after the AV left the bathroom s/he was "fine" and went over to watch the computer. P2 had no prior concerns about the SP and had never seen the SP "tap" other children. After P1 left the classroom P3 did not have any conversations with the SP about the incident.

P1 provided the following consistent information during his/her interview and in a handwritten document:

- P1 said that s/he was in the school age classroom when P2 entered the classroom and said that the SP had "pushed a child's head" and made the child "hit" the table with his/her face/mouth. P1 walked to the toddler classroom and expected to find "chaos" in the room.

- P1 entered the room, saw P3 sitting with the children at the tables and the SP was in the bathroom with the AV. P1 walked to the bathroom and saw the SP wiping the AV's face. P1 said that the AV was not crying, his/her mouth was not swollen, and P1 did not see any blood.

- P1 asked the SP, "What happened?" At first the SP "tried to play it off that nothing really happened." P1 then told the SP that P2 said "something" happened. The SP told P1 that the AV had dumped his/her milk on the table and that that s/he "tapped" the AV on the head and the AV "bumped" his/her face. The SP told P1 that "the inappropriate action did not have any force to it." The SP did not give a reason why s/he "tapped" the AV but took "ownership" of the situation, said that there was "no excuse" for what s/he did, and that it was a "bad choice in the moment."

- P1 asked P3 about the incident. P3 said that the AV poured milk on the table and the SP "tapped" the AV on the side of his/her head. P3 said that the SP used his/her fingertips and that the "tap" had no "force" to it. P1 then told the SP to call the FM and tell the FM about the incident.

- P1 had no prior concerns about the SP.

The SP provided the following information:

- On the day of the incident, the SP worked in the toddler classroom with P2 and P3 and eight children, including the AV. The AV sat at the end of the tables near the cubbies at lunch time and there was a stack of chairs next to the AV. Near the end of lunch time, the SP was leaving the bathroom when the AV poured out his/her milk onto the table.

- The SP walked over to the AV and "tapped" the side of the AV's head with his/her fingertips. The SP said that the AV "must have sat in a way" that caused the AV to fall off his/her chair to the right and "hit" his/her mouth on top of the stack of chairs.

- The SP picked up the AV and gave the AV a hug and told the AV, "I am sorry." P2 said, "[The SP's name] that is not okay" and then P2 walked out of the classroom. The SP took the AV to the bathroom and began to wipe off the AV's face and mouth with a paper towel and the SP saw "a little drop" of blood on the paper towel and then saw a "tiny little" cut on the AV's bottom lip. After the AV's lip was cleaned, the SP sat the AV at the table and placed an ice pack on the AV's lip. The AV was then "fine" and back to

  "normal." P1 then came into the classroom and the SP told P1 about the incident. After P1 left the

classroom, the SP called the FM and left a message about the incident.

- The SP said that when the incident happened, s/he "was not thinking" and it was "kind of a reaction." The SP said that the "tap" was "inappropriate" but "I was not trying to hurt [the AV]." The SP said s/he "felt really bad" about it and said that s/he had "never tapped" any other children.

- The SP said that pouring milk on the tables was a "trend" that was going on for a while and that "a lot" of the children were pouring out milk onto the table when they were almost done with lunch. The SP said that they would "usually" tell the child that pouring the milk was "not okay," clean up the milk, and sometimes poured them more milk. If a child poured their milk more than once, staff persons "assumed" that the child did not anymore milk. The SP said that the AV had already poured one cup of milk during lunch earlier that day.

The facility's *Prohibitive Behavior Tactics* stated that the following behaviors were never to be used by staff and would be grounds for immediate termination: rough handling, name calling, shoving, ostracism, hair pulling, shaming, ear pulling, shaking, corporal punishment and emotional distress, slapping, kicking, biting, pinching, spanking, and hitting.

Facility records showed that prior to the incident P1-P3 and the SP were trained on the facility's *Prohibitive Behavior Tactics* policy and the Reporting of Maltreatment of Minors Act.

Relevant Rule and/or Statute:

Minnesota Rules, part 9503.0055, subpart 3, item A, states that the license holder must have and enforce a policy that prohibits the following actions by or at the direction of a staff persons: Subjection of a child to corporal punishment, which includes, but is not limited to, rough handling, shoving, hair pulling, ear pulling, shaking, slapping, kicking, biting, pinching, hitting, and spanking

Conclusion:

A. Maltreatment:

Consistent information was provided that on August 22, 2024, the AV poured milk out onto the table at lunch and the SP walked over to the AV and "hit" or "tapped" the AV on his/her head. The AV fell over and hit his/her face on the stack of chairs next to him/her causing a cut on the AV's lip that bled. The SP's action of hitting/tapping the AV on the head was inconsistent with the standards of a professional caregiver licensed by the Department of Human Services and a violation of Minnesota Rules, part 9503.0055, subdivision 3, item A. That afternoon when the FM picked up the AV s/he saw a "little" cut on the AV's lower lip.

Although the SP said it was a "reaction," the SP was not immediately next to the AV and had to walk over to the AV to engage with the AV. Although it was not determined how the AV was sitting on the chair or whether that was a factor to the AV falling, the SP's actions of walking over to the AV, who was two years old, and hitting/tapping the AV on the head was not accidental and hitting/tapping a child on the head represents a risk of injury and in this case contributed to the AV falling and cutting his/her lip. Therefore, there was a preponderance of the evidence that the SP's actions represented a substantial risk of physical injury and caused injury to the AV.

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).

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 responsible for the care of the AV at the time of the incident and was trained on the facility's *Prohibitive Behavior Tactics* and the Reporting of Maltreatment of Minors Act prior to the incident.

The SP was 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 physical abuse for which the SP was responsible did not meet statutory criteria to be determined as "recurring" because this was a single incident but was "serious" because the AV sustained a laceration (cut on his/her lip that bled) as a result of the incident.

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 conducted an internal review and determined that policies and procedures were adequate and were not followed at the time of the incident. The facility would provide extra staff to the toddler room to provide better transitions and behavior management.

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

The SP was disqualified from a position allowing direct contact with, or access to, persons receiving services from programs, organizations, and/or agencies that are required to have individuals complete a background study by the Department of Human Services as listed in Minnesota Statutes, section 245C.03. The determination that the SP was responsible for maltreatment and the disqualification of the SP are each 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.