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: 202406879

Date Issued: March 20, 2025

Name and Address of Facility Investigated:

University Nursery School
916 E 3rd St Ste 1
Duluth, MN 55805

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

License Number and Program Type:

802580-CCC (Child Care Center)

Investigator(s):

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Suspected Maltreatment Reported:

It was reported that an alleged victim (AV) was left in the bathroom without a staff person's (SP) knowledge or supervision for 25 to 45 minutes.

Date of Incident(s): August 6, 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 August 22, 2024; from documentation at the facility and through eight interviews conducted with two supervisory staff persons (P1 and P2), four staff persons, (P3, P4, P5, and the SP), and the AV's family members (FM1 and FM2).

The AV was approximately three and half years old and was enrolled in the preschool one classroom at the time of the incident.

The facility's bathroom that was used by the children was located in the hallway and had two toileting stalls, sinks, and a 5-tier shelf near the entrance that contained the children's personal items, extra clothes, and cleaning supplies on the top shelf. Past the bathroom was a set of stairs that led to a classroom and past the stairs was the preschool one classroom. The preschool one classroom had a half door at the entrance and had tables in the classroom for activities and meals. Past the tables was a door that led into another classroom that had a door that led outside onto the preschool playground.

FM1 and FM2 each stated that on the day of the incident at approximately 5 p.m., P2 called and said that when the classroom went out to the playground, the SP, the AV and another child (C) initially stayed inside. While inside the AV asked the SP to use the bathroom and while the AV was in the bathroom, the SP and the C went outside to the preschool playground and left the AV in the bathroom. FM1 and FM2 then talked to the AV who said that s/he asked the SP to use the bathroom. At one point, the AV needed help but did not want anyone to see him/her with his/her pants down so s/he decided to wait for a teacher to come in and help him/her. P2 told FM1 and FM2 that the AV was left alone for approximately 25-30 minutes. FM1 and FM2 said that the AV was "totally fine" and that they had no prior concerns about the facility.

Information obtained showed that on the day of the incident, SP1 and P4 were working in the AV's classroom with 13 children, including the AV. P3 was working in another preschool classroom.

P4 provided the following consistent information during his/her interview and in the *Internal Review*:

- On the day of the incident, P4 started working in the classroom with the SP at nap time. P4 said that there were 13 children, including the AV. After nap, P4 was cleaning up snack and helping the children when the SP asked P4 to take the children who were ready outside. P4 stated that at no point did s/he go into the hallway or help children use the bathroom. The SP also told P4 that P3 would be coming to take two children, not including the AV, to dance class.

- As P4 was getting children ready to go outside, P3 came into the classroom. P3 began to take two children out of the classroom when the AV followed P3 to the hallway door. P3 asked the AV if s/he was going outside. The AV did not respond so P3 asked P4 and the SP, "Do you want me to bring [the AV] outside?" The SP, who was across the room, "yelled" to P3, "[The AV] has to go to the bathroom." P3 then shut the door and took the two children to dance. The SP then walked over to the door, opened the door for the AV, and the AV walked into the hallway as the SP remained by the door.

- P4 then asked the SP if s/he still wanted him/her to take the children outside and the SP said, "Yes." The SP then told P4 to leave the C inside with him/her because s/he needed to talk with the C.

- At 3:10 p.m., P4 had 11 children line up at the door while the C was with the SP and the AV was still in the

bathroom. Before P4 went outside s/he asked the SP, "Do you need any help? Do you want me to wait?" and the SP replied, "No, you are good." P4 then took 11 children, not including the AV, through a classroom and outside onto the preschool playground. When they reached the playground, s/he combined the children with the three other classrooms that were already on the playground. P4 did not see the SP enter the playground but later saw the SP and "assumed" that the SP brought the AV and the C outside. At an unknown point, P4 saw the AV on the playground and the AV was "happy" and playing with his/her friends.

- At approximately 4 p.m., P2 came outside and told P4 to go inside to talk to P1. P4 did so and P1 told P4 that the AV was left alone in the bathroom. P4 did not know how long the AV was left alone but was told that P3 found the AV.

The SP provided the following information:

- On the day of the incident, the SP and P4 were working in the classroom with 11 children, including the AV. The SP was in the classroom and P4 was in the hallway helping children in the bathroom. As the children finished snack, the SP sent them to the hallway to use the bathroom with P4.

- The SP then started putting sunscreen on the children when the AV came up to the SP and asked to go to the bathroom. The SP said, "Yes," s/he saw the AV leave the classroom and go into the hallway. The SP "thought" P4 knew the AV went to the bathroom because P4 was still in the hallway. A couple of minutes later when P4 returned to the classroom, s/he did not have any children with him/her, so the SP "thought" P4 brought all the children back in the classroom. P4 then helped the SP put sunscreen on the rest of the children. After five minutes, P4 asked the SP if s/he could take a group of children outside and the SP said, "Sure."

- As P4 lined the children up to go outside, the SP kept one child (C) inside with him/her so that P4 would be in ratio. The SP "assumed" that P4 had ten children in line, including the AV. The SP said that s/he did not look at the children in line and "trusted" P4 to have all the children. The SP was not sure which route P4 took to get to the preschool playground. A few minutes later, the SP and the C walked through the hallway and out the front entrance to the preschool playground. When the SP transferred the C into the combined class in the iPad the SP saw that P4 had transferred all of his/her children, including the AV, to a combined classroom, on the iPad. At that time, P3 was also on the playground and the SP did not speak with either P4 or P3.

- Five to ten minutes later, at approximately 3:30 p.m., P3 left the preschool playground and ended his/her shift for the day. At some point after, the SP saw the AV on the playground but did not speak with him/her. Between 4:30 to 4:45 p.m., P1 spoke with the SP and told him/her that the AV had been left in the bathroom and was found by P3 and that the AV was alone for approximately 20 to 25 minutes.

- The SP did not remember whether dance class was held the day of the incident and did not remember if anyone came into the classroom and took some children. The SP said that P3 never came into the classroom.

P3 provided the following consistent information during his/her interview and in the *Internal Review*:

- On the day of the incident at approximately 3 p.m., P3 went inside to the PS1 classroom to get two children for dance class. When P3 entered the classroom, the SP and P4 were cleaning up from snack and putting sunscreen on the children.

- P3 had the two children who were attending dance class come to him/her and then asked the SP and P4 if they wanted him/her to take two more children to the preschool playground. The SP and P4 each replied, "Yes." P3 then asked the AV if s/he wanted to come with him/her but the AV replied, "No." So P3 then took the two dance children plus two additional children and left the classroom.

- At that time, the AV began to follow P3 and the four children down the hallway and P3 said to the AV, "You did not want to come with me. You have to go back to your classroom." The SP who was standing at the door said to P3, "No, [The AV] is going potty." P3 said that the SP stood by the classroom door or was in the classroom near a table when the AV walked into the bathroom and P3 took the four children to the hallway in front of the entryway and dropped off two children at dance class.

- P3 then took the additional two children outside through the front and entered the preschool playground though a gate. A "couple of minutes" later, P4 and some children came out to the preschool playground through a classroom door. P4 told P3 that the SP was still inside with the AV and the C. P3 was not sure when the SP came onto the playground, and s/he did not see how many children the SP brought out.

- At 3:40 p.m., the SP left the playground for a short period of time and when s/he came back s/he told P3 that s/he could go home. P3 then walked into the building and to cubbies that were next to the bathroom.

- As P3 was preparing to leave the cubby area, s/he heard from the bathroom. P3 went into the bathroom and saw the AV who was sitting on the toilet. P3 said that earlier around 3 p.m., s/he saw FM2 at the facility and thought that FM2 was still there and had sent the AV to the bathroom. P3 asked the AV, "Did [FM2] get you?" and the AV replied, "No." P3 helped the AV to finish toileting and washing his/her hands. P3 asked the AV, "Who took you to the bathroom?" The AV replied, "[The SP]." P3 said that the AV was "fine."

- P3 then took the AV to the office where P1 was and told P1 that the AV had been alone in the bathroom. P3 then went into the infant classroom and asked if FM2 was still in the building. The infant staff person told P3 that FM2 had picked up the AV's sibling for an appointment and left. P3 then took the AV to the playground and to P5, who gave the AV hugs. The AV then went and played with his/her friends. P3 did not talk to the SP or P4 about finding the AV.

P5 said that on the day of the incident, said that s/he worked with the SP until 1 p.m. and then went onto the preschool playground to put together new play equipment. After snack time three classes came onto the playground and combined on the iPad. P3 brought out eight children and then went back inside and when P3 returned to the playground, s/he had two children from the SP's and P4's classroom. P4 then came out to the playground with ten children later followed by the SP and one child. At approximately 3:45 p.m., P3 left the playground because it was the end of his/her workday. A few minutes later, P3 came outside with the AV to the playground. P3 asked P5 if s/he had taken the AV into the bathroom and P5 replied, "No." P3 then told P5 that the AV was left alone in the bathroom and that the AV said that the SP sent him/her to the bathroom. The AV then went and played with his/her friends. P5 said that the SP routinely sent children to the bathroom and

waited by the door for them. The SP would then help other children and "forget" about the child/ren in the bathroom. P5 then reminded the SP about the child in the bathroom and the SP would go back to the door and watch the bathroom.

P1 and P2 provided consistent information that on the day of the incident, at approximately 3:45 to 3:50 p.m., P3 came into the office with the AV and told P1 that s/he found the AV in the bathroom alone. After P3 took the AV to the playground, P1 told P2 about the incident and had P2 go to the preschool playground so P1 could talk to staff persons. P3 and P4 each provided information to P1 that was consistent with information each provided during their interviews. When P1 spoke with the SP, the SP told P1 inconsistent information. The SP initially told P1 that s/he sent the AV to the bathroom as P3 took the AV outside. The SP then said that s/he thought the AV went outside with P4 and that s/he only had the C in the classroom when s/he took the C outside to the preschool playground. P1 said that the SP was not able to offer any other explanation why the AV was in the bathroom. P1 and P2 had no prior concerns about the SP.

The facility's *Risk Reduction Plan* stated, "Children may never be alone in a closed bathroom. Staff must always accompany children in the hallways and coat areas. Staff are responsible for maintaining visual contact with all children at all times. Children must have direct supervision at all times. Staff are to continually maintain an accurate headcount of children in their care, along with a current list of the names of the children present. Staff will verbally tell staff if dropping off children to the bathroom, from a different group, or to/from the playground if the number of students changes in their care. Staff are to count the children with then upon leaving any area and again upon arriving in any new area."

Facility records showed that prior to the incident, P1-P5 and the SP were trained on the facility's *Risk Reduction Plan* and the Reporting of Maltreatment of Minors Act.

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.

Minnesota Statutes, section 245A.02, subdivision 18, paragraph (a), clause (3), item (e) states that when a single preschooler uses an individual, private restroom within the classroom with the door closed, supervision occurs when a program staff person has knowledge of the child's activity and location and checks on the child at least every five minutes.

Conclusion:

A. Maltreatment:

Information was consistent that on August 6, 2024, the AV, who was three years old, was left in the hallway bathroom unsupervised for approximately 25 to 45 minutes which was inconsistent with the facility's *Risk Reduction Plan*; and a violation of Minnesota Statutes, section 245A.02, subdivision 18, and Minnesota Rules, part 9503.0045, subpart 1, item A. The AV was found by P3 and brought to the playground unharmed.

Given that the AV went to the bathroom in the hallway unsupervised, that when s/he was in the bathroom, the SP

and the C went out to the playground leaving the AV alone in the bathroom, and that the AV was three years old, it was unlikely that the AV would be able to provide for him/herself in an emergency. In addition, staff persons were not aware that the AV was left in the bathroom for 25 to 45 minutes, so in the event of an emergency they would not have been able to intervene. Therefore, there was a preponderance of the evidence 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 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; and/or 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 and P4 were responsible for the supervision of the children, including the AV, who were in the preschool one classroom, and each were trained on the Reporting of Maltreatment of Minors Act and the facility's *Risk Reduction Plan* prior to the incident.

P3 and P4 provided consistent information that the SP sent the AV to the bathroom. P3 said that when s/he left the classroom with four children, the AV began to follow them out of the classroom and down the hallway. P3 said to the AV, "You did not want to come with me. You have to go back to your classroom." The SP who was standing at the door said, "No, [The AV] is going potty," and the SP stood by the classroom door or was in the classroom near a table when the AV walked into the bathroom. P4 said that the SP walked over to the door, opened the door for the AV, and the AV walked into the hallway as the SP remained by the door. At which point, P4 asked the SP if s/he still wanted him/her to take the children outside and the SP said, "Yes." The SP then told P4 to leave the C inside with him/her because s/he needed to talk with the C and so P4 and the children went to the playground while the SP, the AV, and the C remained inside.

The SP provided different accounts of the incident to this investigator and to P1. The SP told this investigator and initially P1 that s/he sent the AV to the bathroom and told this investigator that P4 was in the hallway and s/he "trusted" that P4 had the AV in his/her care. The SP also told P1 that s/he thought the AV went outside with P4 and that s/he only had the C in his/her care.

Given that the information provided by P3 and P4 and initially the SP was similar it was more likely that when P4 was in the classroom, the SP sent the AV to the bathroom without the supervision of a staff person, which because the bathroom was not an individual, private restroom within the classroom, was a violation of Minnesota Statutes, section 245A.02, subdivision 18, and Minnesota Rules, part 9503.0045, subpart 1, item A.

P4 then confirmed with the SP prior to leaving the classroom that s/he was to continue outside and took 11 children to the playground. The SP acknowledged that s/he did not look at the children in the line before they went outside.

Given that the SP was the staff person who sent the AV to the bathroom unsupervised and was sole staff person who remained in the classroom when P4 and the other children went outside, the SP was responsible for the care and supervision of the AV at the time of the incident. Therefore, P4's responsibility was mitigated, and 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 because it was a single incident, and the AV did not sustain an 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 conducted an internal review and determined that policies and procedures were adequate and were not followed at the time of the incident. 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 disqualification. The determination that the SP was responsible for maltreatment is subject to appeal.

On March 20, 2025, the facility was issued a Correction Order for the violations 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.