**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:** 202500084

**Date Issued:** June 4, 2025

**Name and Address of Facility Investigated:**

Playhouse Child Care Center
1701 9th Ave. N
St. Cloud, MN 56303

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

**License Number and Program Type:**

806228-CCC (Child Care Center)

**Investigator(s):**

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**Suspected Maltreatment Reported:**

It was reported that a staff person (SP) held an alleged victim (AV) causing marks on the AV's right forearm.

**Date of Incident(s):** December 30, 2024

**Nature of Alleged Maltreatment Pursuant to Minnesota Statutes, section 260E.03, subdivision 15, paragraph (a), clauses (1) and (2); subdivision 18, paragraph (a); and subdivision 23, paragraph (a):**

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.

"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 January 16, 2025; from documentation at the facility; and through eight interviews conducted with two supervisory staff persons (P1 and P2), three facility staff persons (the SP, P3, and P4), the AV, and the AV's family members (FM1 and FM2).

The AV was three years old and enrolled in a preschool classroom at the time of the incident. The AV attended the facility Mondays, Wednesdays, and Fridays.

The preschool classroom had tables set up on one side of the classroom and areas for learning on the other side. There was a large carpet for group time. Near the tables there was a small "take a break" area for the children. On the wall there was a mounted sensory board, and then a little carpet with a bookshelf and soft block to sit on.

The AV said the SP was "mad" at the AV and did "this" (the AV showed this investigator a grabbing motion to his/her right arm). The AV also said the SP scratched the AV and that the AV was facing a wall.

FM1 stated that on Monday before New Year's Day (this would have been December 30, 2024), s/he received messages from the facility during the day that the AV had a "tough" day. When FM1 picked up the AV from the facility, the AV said the SP held the AV "tightly" with two hands. The SP walked over at that time and s/he and FM1 talked about the AV's day and that the AV had a "rough" time with things in the classroom, so the AV was separated to calm down. At that time there were no visible marks and no concerns. On Wednesday (January 1, 2025), the AV and FM1 were out shopping with friends when the AV took off his/her coat and FM1 noticed three "finger" shaped bruises on the AV's right arm from his/her elbow down the forearm. When FM1 brought the AV back to the facility on Friday (January 3, 2025), the AV was not scared and wanted to go back to his/her classroom. FM1 said the AV could be "difficult" and FM1 did not think the marks were done "maliciously."

FM2 saw the photos that FM1 took, but did not see the bruises on the AV directly. FM2 heard that a staff person pulled the AV aside to talk to the AV about not listening, and the staff person was a "little too rough" with the AV's forearm and it left bruises.

Information was consistent that the SP, P3 and P4 worked in the AV's classroom on December 30, 2024.

The SP provided the following information:

- On an unspecified date, the SP remembered taking the AV over to an area of the room where the SP could still see the other children and the other staff persons could still see the AV and the SP. The SP was down at the AV's level and the SP held the AV's arms close to the AV's body so that the AV could focus on what the SP was telling the AV.

- The SP stated that his thumb was on the AV's forearm, but his/her fingers were on the back of the AV's arm right below the AV's elbow. The AV said, "Ow, you're hurting me," so the SP let go of the AV's arms and the SP put three fingers on the AV's chest to make sure the AV still focused on the SP. The SP said the AV had no other reaction and the AV did not cry.

- After they were done talking, the AV went and played at the tables, then went to group time, and then it was lunch time.

- The next time the AV was at the facility, the AV acted the way the AV "normally" did, and s/he did not seem "off." The SP saw bruises on the AV's arm that day. The SP described the bruises as two distinct spots right below the elbow that looked like someone grabbed the AV's arm "roughly" and "squeezed pretty good." The SP said the marks were green and a little bigger than the SP's thumb.

- The SP did not think how s/he held the AV caused the AV's bruises.

- The SP was trained to use words to try to redirect a child, and if a child needed more to get down to the child's level to speak with them. If a child needed to be moved away from a situation the SP tried to take the child's hand, but if the child pulled back, the SP picked the child up under the shoulders.

P1 provided the following information:

- On an unknown date, FM1 brought the AV to the facility and showed P1 two marks on the AV's right arm. P1 described the marks as an inch long right next to each other and they were a yellowish green discoloration like a bruise. The AV told FM1 that the SP "grabbed" the AV "really tight." The AV did not say much to P1, seemed "happy," and wanted to go to his/her classroom.

- P1 called P2. When P2 arrived at the facility, s/he and P1 brought the SP into the office and had a conversation about the AV having marks on his/her arm. The SP did not recall any incidents happening. P2 gave the SP a training packet and the SP was sent home.

- When FM1 picked up the AV that afternoon, the AV told FM1 that the SP went home, and that the AV "missed" the SP.

- P1 said there was a "quiet" area in the classroom by the bathrooms with cushions and books if children want to take a break. Staff persons were trained to use positive reinforcements and get down to the child's level. P1 had no prior concerns with the SP.

P2 provided the following information:

- On Friday, January 3, 2025, P2 heard from P1 that FM1 had concerns about the AV having marks on his/her arms. P2 arrived at the facility before FM1 left and P2 spoke with FM1. FM1 said that when s/he picked up on Monday (December 30, 2024), the AV commented that the SP "squeezed" the AV's arm

"hard." On Wednesday (January 1, 2025), FM1 noticed two inch-long bruises on the AV's arm.

- When P2 went into the preschool classroom on Friday, January 3, 2025, s/he asked the AV what happened. The AV said, "[The SP] squeezed me really hard." The AV said it very nonchalantly and then went off to pick up toys. P2 described the two marks as one-half inch to one inch in size on the AV's right forearm.

- P2 spoke with P3 and P3 did not remember anything happening on December 30, 2024, that would have caused those marks. P2 then spoke with the SP. The SP did not remember grabbing the AV's arms. P2 said the SP seemed "in shock" and that s/he "never" had the intent to hurt a child. P4 had left early that day, so P2 spoke with P4 the following Monday. P4 did not remember anything concerning happening on December 30, 2024, but stated that the SP was "harder" on children with behavior issues.

- P2 recalled an incident in October 2024, when s/he went into the preschool classroom at naptime and there was a child struggling and the SP was holding the child as the child was trying to get away. At that time, P2 reminded the SP that staff persons cannot restrain a child. P2 said staff persons were trained to use positive redirection.

P3 provided the following information:

- P3 said the incident would have happened on a Monday, but s/he did not recall the date. P3 did not remember anything specific that happened between the AV and the SP on that Monday that would have left bruises on the AV's arms.

- The next time the AV was at the center, s/he went up to P3 and said, "Look at these bumps on my arm" while the AV took of his/her coat and the AV briefly showed P3 his/her arm. P3 did not get a good look since the AV had on long sleeves and pulled his/her shirt down quickly after s/he told P3 to look. P3 did not remember which arm, but said there was a light bruise below the inside of the AV's elbow.

- P3 stated the AV "loved" the SP and acted "normal" with the SP even after the event before the staff persons knew of the bruises on the AV's arm. P3 said the SP did not treat the AV any differently than other children.

- If the SP needed to move a child s/he picked them up under shoulders by the torso. If a child was falling the SP might grab a child's upper arm to stop the child from falling, but nothing with the intent to harm. The SP did get frustrated and flustered with the classroom having a lot of children and some children not listening and climbing on things, but P3 said the SP did not take the anger out on the children. P3 was trained to use a positive approach and redirect children to a positive activity when children were making unsafe choices.

P4 provided the following information:

- P4 did not notice the SP grab the AV, but recalled an incident a few months back where a child was running around the classroom and not listening to the SP. The SP stopped the child, held the child's wrist in front of the child and yelled at the child, and the child cried.

- P4 said staff persons were trained to get down at a child's level, and to get a child to calm down by reading a book. There was a take a break area available and children could come back to the group whenever they were ready.

- If a child needed to be moved from an area, staff persons were to ask the child to walk and if they did not walk willingly, staff persons were to pick a child up under their armpits. P4 did not pay attention to how the SP moved children.

This investigator reviewed photos provided by FM1 from January 1 and 3, 2025, and noted the following:

- The photos from January 1, 2025, showed three marks on the AV's right forearm. All three were light purple and lined up going down the AV's forearm. The largest mark was near the crease in the AV's elbow, the next mark was a little smaller and these two marks looked like fingerprints. The last mark looked like a small circle, like it had been made by the tip of a finger.

- The photos from January 3, 2025, showed the marks had turned yellow. The middle mark was less prominent than the other two marks.

The facility's *Behavior Guidance Policies* regarding the "take a break" area provided the following information:

- Staff [persons] will encourage children to "take a break" when they need alone time, time to settle down, or time to think about how their actions are affecting others around them.
- Each classroom will have a designated area for children to "take a break" and separation repots will be completed per licensing requirements.
- The "take a break" area in your room will include various calming activities, book, sensory items, and/or special items available to a child only in the area at a specific time.
- The "take a break" area will not be used for discipline, but children should be encouraged to make use of this area any time they want to be alone or get away from the action for a bit.

The facility *Behavior Guidance Policies* also stated, "The use of physical restraint other than to physically hold a child where containment is necessary to protect a child or others from harm" was a prohibited action.

Facility documentation showed the SP, P1, P2, P3, and P4 each received training on the facility's *Behavior Guidance Polices* and the Reporting of Maltreatment of Minors Act.

*Relevant Rules and/or Statutes*

Minnesota Rules, part 9503.0055, subpart 1, item A, states that facilities must ensure that each child is provided with a positive model of acceptable behavior.

Minnesota Rules, part 9503.0055, subpart 3, item F, prohibits the use of physical restraint other than to physically hold a child when containment is necessary to protect a child or others from harm.

**Conclusion:**

A. Maltreatment:

The SP provided information that on the day of the incident, the AV was running around the room, so the SP held out his/her arm to stop the AV from running. The SP and the AV then went to the "take a break" area of the classroom. The SP got down to the AV's level and held onto the AV's forearms. The AV said, "Ow," so the SP released the AV's arms, and the SP then placed his/her fingertips on the AV's chest to keep the AV's attention on the SP while the SP spoke with the AV about making safe choices in the classroom. At pick up, the AV told FM1 that the SP grabbed the AV, and it hurt. Two days later, FM1 noticed bruising on the AV's right forearm. Photos taken by FM1 on January 1, and January 3, 2025, showed three bruises on the AV's right forearm that were consistent with being grabbed.

The AV was not a danger to him/herself or others at the time of the incident and the conduct of physically restraining the AV was not accidental; was inconsistent with the facility's *Behavior Guidance Policy*; and was a violation of Minnesota Rules, part 9503.0055, subpart 1, item A and subpart 3, item F. In addition, the AV experienced and expressed pain during the interaction and sustained bruises in the area s/he was restrained, and there was no information that the AV's injuries were sustained by any other means.

Therefore, there was a preponderance of the evidence that there was a failure to supply the AV with reasonable and necessary care and a failure to protect the AV from conditions or actions that seriously endangered the AV's physical health when reasonably able to do so. In addition, there was a preponderance of the evidence that a staff person's conduct inflicted a physical injury to the AV, other than by accidental means.

It was determined that neglect and physical abuse 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. "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 AV's care and supervision at the time of the incident. The SP received training on the facility's *Behavior Guidance Policy* and the Reporting of Maltreatment of Minors Act. 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 was not "recurring" but was "serious" maltreatment. The SP was responsible for a single incident of physical abuse that resulted in three bruises to the AV's right forearm. It was determined that the neglect for which the SP was responsible was not "recurring" or "serious" as it was a single incident and the AV did not need care of a physician.

The SP was disqualified from providing direct contact services.

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 and followed by the SP. (Note: information was provided to the DHS investigator that was not available to the facility during their internal investigation.) The SP no longer worked at the facility.

**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 June 4, 2025, the facility was issued a Correction Order for the violations outlined in this report.

During the course of the investigation, it was determined that six background study violations occurred. On June 4, 2025, the facility was issued a fine of $1,200 ($200 for each background study violation). The Order to Forfeit a Fine is subject to appeal.

**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.