

**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."*

On June 18, 2025, most of the children and family work, including investigations of maltreatment at childcare centers, at the MN Department of Human Services (DHS) Office of Inspector General transferred to the new Minnesota Department of Children, Youth, and Families (DCYF), as directed by state law. While this investigation began under DHS, pursuant to Minnesota Statutes, section 15.039, subdivision 2, this Investigation Memorandum is being issued by DCYF pursuant to that transfer.

**Report Number:** 202500239

**Date Issued:** July 31, 2025

**Name and Address of Facility Investigated:**

Jardin Summit Hill  
130 Victoria St N.  
St. Paul, MN 55104

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

**License Number and Program Type:**

1081950-CCC (Child Care Center)

**Investigator(s):**

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**Suspected Maltreatment Reported:**

It was reported that a staff person (SP) pinched an alleged victim (AV) during naptime causing a mark on the AV's left arm.

**Date of Incident(s):** December 19, 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 24, 2025; from documentation at the facility; and through six interviews conducted with two supervisory staff persons (P1 and P2), two facility staff persons (the SP and P3), the AV, and the AV's family member (FM). Video footage was no longer available for this investigator to review.

The AV was three years old and enrolled in a pre-kindergarten classroom at the time of the incident.

The pre-kindergarten classroom had tables and shelves lined with items for the different discovery areas within the classroom. During naptime, cots were laid out in two rows on a large rectangular carpet.

The FM provided the following information:

- On Thursday, December 19, 2024, the FM picked the AV up from the facility. As they walked to the car, the AV told the FM that the SP "pinched" the AV. The FM talked with the AV about what happened. The AV said during naptime the AV was sleeping when the SP pinched the AV, and the AV cried. The SP let the AV cry and then P3 came and gave the AV a hug. The FM thought the AV might be telling a "story."
- Later that evening, when the FM gave the AV a bath, s/he noticed a mark on the AV's left forearm. The mark was the size of a thumbnail and was "pretty" brown and purplish in color. The FM asked the AV what happened, and the AV told the FM, "I told you teacher pinched me." The FM took a photo of the mark and emailed the facility that evening around 8 p.m.
- On Friday, December 20, 2024, around 4:30 p.m., P1 told the FM that the facility received the FM's message and needed more time to respond. On Monday, December 23, 2024, the FM reached out to the facility and did not hear anything. The facility was closed for a few days, and the FM kept the AV home for the holidays.
- On January 2, 2025, the families at the facility received a text message that the SP no longer worked at the facility as of this date due to personal reasons.
- On January 8, 2025, P2 reached out stating that they had watched the video of the incident and noted the following:
  - The AV laid on his/her cot in the middle of the classroom, and s/he was awake. Most of the other children were asleep, and the AV was singing loudly, but not bothering anyone.

- At 1:15 p.m., P3 left the classroom for his/her scheduled break. The SP asked the AV several times to move his/her cot to a different part of the classroom where s/he was less likely to disturb the other children.
  - The AV continued to lay on his/her cot singing. P2 was not sure if the AV did not hear the SP or if the AV was ignoring the SP.
  - The SP picked up the AV and moved him/her to the other side of the SP. P2 was not sure if this was what caused the mark, but it might have felt like a "pinch."
  - The AV went to his/her cot and cried. Several minutes went by and the SP asked the AV what was wrong. When P3 returned the AV ran over and hugged P3.
- P2 reviewed the video with the SP, and the SP remembered the incident, but did not think s/he hurt the AV. The SP remembered his/her training and said if s/he hurt the AV, it was unintentional.
  - The mark on the AV's arm lasted a few weeks. The FM had no prior concerns about the AV's care at the facility, but stated the AV had only been in that classroom since the beginning of December. Since the incident, the AV was more "sensitive" and only wanted to go to school if P3 was there.

The AV said that on an unknown date, s/he was sleeping and the SP "pinched" the AV and it "hurt." The AV did not remember if the SP said anything to the AV when s/he pinched the AV, and the AV "forgot" to tell a staff person once s/he woke up. When this investigator asked which arm the SP "pinched" the AV held up his/her right arm and pointed to the approximate location the mark would have been on his/her left arm.

The SP provided the following information:

- On an unknown date, the AV was sitting on his/her cot singing during naptime. Some of the other children were already asleep. The SP asked the AV to lay down on his/her cot. The AV did not so the SP went over to the AV and laid the AV down on his/her cot. The SP stated that during naptime, the staff persons "usually" laid the children down, put a blanket on them, and arranged them so they were in the right position.
- The SP did not ask the AV to move his/her cot, but to lay down on his/her cot. After the SP laid the AV down, the AV cried because s/he did not want to go to sleep. The AV stayed laying down and then the SP recalled going on his/her scheduled break. At the time s/he asked the AV to lay down, there were no other staff persons present.
- On an unknown date at the end of December 2024, P2 called the SP in for a meeting and the SP was told that the AV had a bruise on his/her upper arm and the SP was asked if s/he grabbed the AV. The SP recalled the events above to P2 and stated that s/he laid the AV down.
- The SP demonstrated that when s/he laid the AV down, the AV was sitting with his/her legs out in front of him/her and the SP's hands were on the upper part of the AV's arm as the SP laid the AV down. The SP was trained to lift a child by their torso and not pull on their arms.
- The SP did not think that s/he grabbed the AV with enough force to cause the mark, but when P2 told the SP about it, the SP felt bad if there was a possibility s/he caused the bruise.

P1 provided the following information:

- On an unspecified Friday, P1 arrived at the facility and helped staff persons in the morning. After that, P1 went to the office and read the FM's email from the night before. P1 let P2 know what happened and they reviewed the video footage. P1 saw the bruise, did not remember if it was the right or left arm, but stated it was a "very small" coloring on the AV's upper arm.
- In the video, the SP was the only staff person in the classroom and the AV was on his/her cot singing. The SP did not use the proper technique and grabbed the AV by one arm, which was how P1 thought the AV received the bruise. The SP told the AV to go to sleep, and P1 saw the AV cry "a bit" when the SP grabbed the AV. The AV then laid down and went to sleep.
- P1 had no prior concerns with the SP and said that the SP was an "excellent teacher." Staff persons were trained to move children by the torso.

P2 provided the following information:

- On Friday, December 20, 2024, around 10 a.m., P1 called P2 and told P2 to look at the email the FM had sent the night before, December 19, 2024. In the email, the FM said when s/he picked the AV up on Thursday (December 19), the AV said the SP pinched the AV, the AV cried, and no one helped the AV. The FM wanted to get more context of what happened.
- P1 told P2 that s/he went and checked on the AV already and there was a bruise that was green. The AV told P1 the SP caused the bruise, but did not remember what happened.
- P2 and P1 reviewed video footage of the incident. P2's description of the video content to the DCYF investigator was consistent with the description P2 provided to the FM. P2 added that the AV was laying down and the SP sat the AV up with one hand, and then put his/her other hand on the AV's other arm to help the AV stand. (Note: P2 stated that this was not the appropriate method to lift a child).
- Staff persons were trained to have the preschool children walk, but if they needed to be carried staff persons were supposed to lift children by their torsos. P2 had no prior concerns with the SP and stated that s/he was a "loving" staff person and P2 had never heard the SP raise his/her voice.
- P2 saw the bruise on the photo the FM sent and stated it was about the size of a penny. P2 thought it was on the AV's left arm.

P3 said "all" the children "loved" the SP and the SP reacted "very good" with the children. P3 did not recall a situation where a child approached him/her crying when P3 returned from lunch break. P3 was trained to pick a child up by the waist if the child needed to be picked up. P3 did not recall the SP picking up a child by an arm. P3 stated that s/he was not working from December 10-20, 2024. However, facility records showed P3 worked 39.47 hours that week. P3 had no concerns with how the SP treated children.

This investigator reviewed photos taken by the FM on December 19, 2024, around 8 p.m., and saw a small red

circular mark on the top of the AV's left arm slightly below his/her elbow.

The facility's *Program Policies and Procedures* regarding behavior guidance stated, "Positive reinforcement is the best approach to discipline. The following actions are prohibited by or at the direction of a staff person: 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, or spanking."

The *Program Policies and Procedures* also showed if a child was not behaving appropriately, staff persons used the following positive guidance techniques:

1. Ignoring: Ignoring a child who is trying to gain attention by acting out may be an appropriate response, unless it is a behavior that is unsafe.
2. Redirection/Distraction: This technique offers an alternative to a child such as suggesting a new activity, or a different toy, encouraging independent play, or interacting with the child in a different way.
3. Discussion: Discussing with the child how their behavior is inappropriate and engaging with the child other words or methods that would suggest a more appropriate response.
4. Reasonable Consequences: The staff [person] may implement reasonable consequences such as taking away a toy if the child used the toy to hit another child.

Facility documentation showed that the SP, P1, P2, and P3 each received training on the facility's *Program Policies and Procedures* regarding behavior guidance 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 A, prohibits the use of corporal punishment including but not limited to in part, rough handling, shoving, pinching, or hitting.

**Conclusion:**

**A. Maltreatment:**

The SP stated that during the incident, s/he was not trying to move the AV but went to help the AV transition from a seated position to laying down so the AV could take a nap. However, the AV provided consistent information to the FM and the DCYF investigator that the SP pinched him/her during naptime, and that was how s/he sustained a mark on his/her left forearm. Information from P1 and P2, who each watched video footage of the incident, was consistent that on December 19, 2024, the SP was the only staff person working in the AV's classroom during naptime. The AV was laying down, but was still awake and singing, and the SP wanted to move the AV's cot to another spot, so s/he did not wake the other children. The SP grabbed one of the AV's arms and pulled the AV into a sitting position, at which point the AV began to cry.

The AV was not a danger to him/herself or others at the time of the incident. The SP's action of grabbing the AV's

arm to move the AV was not accidental; was inconsistent with the facility's *Programs Policies and Procedures* for behavior guidance; and was a violation of Minnesota Rules part 9503.0055, subpart 3, item A, and Minnesota Rules, part 9503.0055, subpart 1, item A. 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, given the appearance of the AV's injury was consistent with the AV's description of being pinched, that the location of the injury matched the circumstances of the incident, and that there was no information the AV's injury was sustained by other means, there was a preponderance of the evidence that the SP inflicted a physical injury to the AV by means other than accidental.

It was determined that neglect and physical abuse occurred ("neglect" means 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 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):

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 *Program Policies and Procedures* regarding behavior guidance and the Reporting of Maltreatment of Minors Act. The SP was responsible for maltreatment of the AV.

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 Children, Youth, and Families 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 Children, Youth, and Families, Office of Inspector General:**

The Department of Children, Youth, and Families informed the Department of Human Services, Office of Inspector General, Background Studies Division that the SP was determined responsible for maltreatment. The determination that the SP is responsible for maltreatment is subject to appeal.

Minnesota Statutes, section 260E.06, subdivision 1, requires mandated reporters at a facility to immediately report suspected maltreatment. This investigation determined that two individuals failed to report suspected maltreatment as required. A letter from DCYF was sent to each of these individuals regarding their failure to report the suspected maltreatment and potential consequences for future such failures.

On July 31, 2025, the facility was issued a Correction Order for the violations outlined in this report.

In addition, it was determined that facility mandated reporters, including two mandated reported in a management role had knowledge of the alleged incident and did not report the incident as required. The license holder was ordered to forfeit a fine of \$200 for failure to report maltreatment. 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 Children, Youth, and Families.