

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: 202504106

Date Issued: October 31, 2025

Name and Address of Facility Investigated:

University Nursery-Copper Top
230 E Skyline Parkway
Duluth, MN 55811

Disposition: Maltreatment determined as to neglect of an alleged victim by two staff persons.

License Number and Program Type:

1012862-CCC (Child Care Center)

Investigator(s):

Judie Schwanke
Minnesota Department of Children, Youth, and Families
Office of Inspector General, Licensing Division
PO Box 64242
Saint Paul, Minnesota 55164-0242
651-529-8268
Judith.schwanke@state.mn.us

Suspected Maltreatment Reported:

It was reported that two staff persons (SP1 and SP2) left an alleged victim (AV) unsupervised on a playground for between 5 and 45 minutes.

Date of Incident(s): May 5, 2025

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 May 20, 2025; from documentation at the facility and through five interviews conducted with the AV, the AV's family member (FM), a supervisory staff person (P), SP1 and SP2.

Facility documentation showed the AV was almost four years old and enrolled in the Preschool 1 classroom at the time of the incident.

Facility documentation showed that on May 5, 2025, before 9:30 a.m., the AV was left on a playground when the AV's class went inside for breakfast.

The AV stated that there was a time when s/he was playing on the playground and SP1 and SP2 did not "look around" for the AV and the group "left" the AV on the playground. The AV stated that the playground gate was open while s/he was on the playground alone. The AV played on the playground until SP1 came back to the playground and "carried" the AV inside.

During the site visit, the DCYF investigator observed the following:

- The facility was located in a large community building which was surrounded on three sides by busy two- and four- lane roads with speed limits of 30 and 40 miles per hour. There were large parking lots on two sides of the building. The community building frequently had community persons visiting and working in the building. The facility was located in one area of the building.
- The facility's playgrounds were located behind the building, across a driveway that children crossed to access the playgrounds. The toddler playground and the preschool playground were adjacent to one another. There was a large climber in the middle of the playground and several smaller play structures were placed around the playground. A chain link fence with an unlocked gate surrounded the playground.
- Inside the door to the facility, there was a set of stairs that led down to the Preschool 1 classroom. In the stairwell was a vestibule area that held the children's belongings.
- Inside the Preschool 1 classroom were tables, chairs, and a binder that held a "*p chart*." The *p chart* was a monthly meal/snack count and attendance record. There was also a clipboard with a *Transition/Combining Checklist*. The checklist had a spot to log transitions, including the time of the transition, the number of children present, and the staff persons responsible for the transition. It also had a numbered list of children present for the day.

Facility staff persons used a computer app called Brightwheel to keep a record of the children in their classroom each day and to count each child each time a group of children transitioned from one area to another.

The FM stated that s/he received a phone call from the P after the incident. The P told the FM that the AV was "fine," but had been temporarily left on the playground alone. The children lined up to go inside and another child was being dropped off so SP1's and SP2's "count" was off. The AV did not line up like s/he was "supposed to," and hid on the playground when the others went inside. At snack time, SP1 and SP2 recounted the children and found that the AV was missing. SP1 went back outside and found the AV playing on the playground. That evening the FM and the AV talked about the incident. The AV told the FM that s/he wanted to play outside when it was "quiet," and no other children were around. The AV told the FM that s/he was not "scared," and the FM thought the AV enjoyed being on the playground alone. Prior to this incident, the FM did not have concerns with the facility and "loved" everyone at the facility.

The P provided the following information:

- On May 5, 2025, at approximately 9:30 a.m., the P was in his/her office and SP1 came in and told him/her that when the group came in from outside, SP1 checked the breakfast *p chart* and realized that the AV was not inside. SP1 "dropped everything" and ran out to the playground and found the AV under a climber. SP1 asked the AV why s/he did not line up and the AV told SP1 that s/he was not "done playing." The P then called the FM and told him/her that the AV had been left on the playground and then between 10:15 and 10:30 a.m., the P checked on the AV in the classroom. The AV did not "really talk" with the P but the AV did not seem upset.
- The P asked SP1 and SP2 how the AV was left on the playground unsupervised and they each told the P that a child was dropped off that was not added to the *Transition/Combining Checklist* and that child's parent did not check him/her in on the app. There were 17 children present at the time of the incident, but there were only 16 children documented present on the checklist and in the app. When the group went inside, SP1 and SP2 counted 16 children three times (on the playground, going into the facility, and going into the classroom) but because one child was not added to the checklist, SP1 and SP2 thought they had all of the children when they transitioned from the playground to the classroom. Neither SP1 nor SP2 completed a name to face check when the group left the playground.
- SP1 told the P that the AV was unsupervised for approximately 45 minutes and SP2 told the P that the AV was unsupervised for approximately 10 minutes. The P estimated the AV was unsupervised for approximately 30 minutes, based on how long it typically took for the group to transition inside, wash hands, and sit down for breakfast.
- When staff persons transitioned children from the playground to the classroom, the staff persons were trained to line up children along the fence inside the playground and count them. Then staff persons looked at the app and matched the counted number with the number in the app and the number on a *Transition/Combining Checklist*. Staff persons then completed a "name to face" check in the app. As children walked into the facility and again as they walked into the classroom, staff persons completed a "head count."

SP1 and his/her written account of the incident provided the following information:

- On the day of the incident, SP1 began work at 8 a.m. The Preschool 1 children, including the AV, were already on the playground when SP1 arrived. SP1 went to the playground and checked the

Transition/Combining Checklist and completed a head count and there were 14 children present. That number did not match the app number and SP1 realized that a child had not been checked in so SP1 checked that child in on the app. SP2 arrived to the playground at 8:30 a.m., and two more children arrived on the playground between 8:30 and 8:45 a.m.

- At 8:45 a.m., it was time to go inside for breakfast and SP1 and SP2 had the children line up along the fence inside the playground. SP1 then walked around the playground to make sure all the children were in line while SP2 stood at the front of the line. SP1 recalled seeing the AV towards the end of the line. When SP1 completed his/her walk around the playground, s/he walked past the line and counted 16 children. SP1 did not look at the app but the "paper" form showed there were 16 children present. SP2 had the clipboard and SP1 "confirmed" the number 16 with SP2.
- With SP1 at the front of the line and SP2 at the end of the line, SP1 opened the gate and led the children across the parking lot to the facility. SP1 told this investigator that once the group arrived at the facility door, SP1 opened the door, held it open, and started to count the children as they walked inside but was interrupted when a child was dropped off and joined the group. SP1 did not have the clipboard so s/he did not add that child to the checklist. SP1 counted 16 children but "should have counted 17." SP1's written account stated that once s/he was at the facility door, SP1 counted 16 children as they walked inside the facility.
- Next, the group went into the classroom. SP1 did not complete a count at this time because s/he "knew" s/he would count the children when s/he completed the *p chart*. SP2 assisted children with the bathroom and SP1 set out 16 cups and plates. The children sat down for breakfast and SP1 gave out cereal and bananas. At approximately 9:15 a.m., SP1 marked the AV's name on the *p chart* without saying the AV's name "out loud." SP1 checked off 17 children on the form but only had set up 16 cups and plates. SP1 checked the app and the total showed there were 17 children checked in and stated out loud that there was a discrepancy in the numbers. SP2 looked at the *p chart* and told SP1 that the AV was checked off on the chart but was not in the classroom.
- SP1 "threw" his/her things and went to the playground. The playground gate was open and SP1 found the AV on the playground approximately ten feet from the playground gate near a slide and a "stack of sand and wood chips." SP1 asked the AV what s/he was doing and the AV told SP1 that s/he was building a "sand castle." SP1 picked up the AV and carried him/her into the classroom for breakfast and then went and told the P what had happened.
- SP1 did not "think" s/he had been "really" trained on how to complete transitions and stated there "should be just one" form for attendance and counts. SP1 did not use the tablet for the Brightwheel app because the tablet did not get service on the playground. SP1 used his/her cell phone for the app however using his/her cell phone was against facility policy. SP1 stated that the app was not accurate because "every day" parents forgot to check their child in on the app, so SP1 relied on the paper *Transition/Combining Checklist*.

SP2 and his/her written account of the incident provided the following information:

- On the day of the incident, SP2 began work at 8:30 a.m. When s/he arrived at the facility, the Preschool 1 children, including the AV, were already on the playground. SP2 walked out to the playground and checked the *Transition/Combining Checklist* and the app on his/her phone and both showed there were 16 children present. The AV was under a climber playing in dirt. At approximately 8:50 a.m., SP1 and SP2 had the children line up. SP2 was at the front of the line and saw the AV in the line and then SP2 left the line to gather other children that had not come to the line. When all the children were in line, SP2 counted 16 children. SP2 did not hear SP1 count the children. SP2 thought SP1 counted the children silently, because SP2 told SP1, "16," and then SP1 said, "16," back to him/her. SP2 then opened the gate and led the children out of the playground and across the parking lot to the facility. SP1 was at the end of the line and had the *Transition/Combining Checklist*.
- SP2 held the door to the facility open and counted 16 children as they walked through the door. The children walked inside and sat on the stairs. As each child calmed and began to sit "nicely," SP2 called their name to line up at the classroom door. Once the children were lined up, SP2 opened the door and the children went inside to sit in the "potty line," and SP2 put out bowls and cups. SP1 watched the children to ensure they all used the bathroom and washed their hands before breakfast. During this time another child arrived at the classroom.
- After approximately 13 minutes, the children sat at the tables for breakfast and SP1 grabbed the *p chart* and filled it out. After a "couple of minutes," SP1 realized there were 18 children on the list and s/he only counted 17 children at the breakfast table and told that to SP2. SP2 looked around and saw that the AV was "checked" for breakfast but was not at the tables or in the bathroom. SP1 asked SP2 where the AV was, and SP2 told SP1 that the AV was not there. SP1 then ran out of the room.
- A "couple of minutes later," SP1 and the AV came into the room. The AV "seemed calm," and was not crying. The AV walked to his/her chair and sat down for breakfast and SP1 left the classroom. SP2 sat near the AV and asked the AV what happened. The AV told SP2 that s/he was "building a sand castle." SP2 asked the AV if s/he knew the group left and the AV replied, "Yeah." SP2 asked the AV if s/he was scared and the AV replied, "No."
- SP2 looked at the *Transition/Combining Checklist* and saw that a child who had arrived at 7 a.m. was not on that list. SP2 looked at the app and saw that another child was not added to the app. There were 18 children present but only 17 listed on the checklist and in the app so the number of children was incorrect on both.
- When transitioning children from inside to outside, SP2 was trained to line up the children along the fence inside the playground, look at the checklist, and count the children. When children walked through the door, SP2 was trained to count the childrens' heads. SP2 felt his/her training was not adequate because s/he received one day of training before working in a classroom.

According to www.wunderground.com, on May 5, 2025, at 8:35 a.m., the temperature in Duluth, Minnesota was 43 degrees Fahrenheit with no precipitation.

The Brightwheel app showed that on May 5, 2025, the AV was checked into the playground at 7:49 a.m. and checked out of the playground and into the Preschool 1 classroom at 9:39 a.m.

The May 5, 2025, *Transition/Combining Checklist* documented only one transition of 14 children to the playground at 10:46 a.m. There were no transitions documented at approximately 8:30 a.m.

The May 5, 2025, *p chart* showed that there were eighteen children, including the AV, present for breakfast.

The facility's *Risk Reduction Plan* stated that children had direct supervision at all times. Staff persons had an accurate "headcount" of children, especially when moving from one area to another. Staff persons enforced transition rules to ensure that all children were supervised at all times. Family members signed their child in and out of the facility using the app. Staff persons also signed children in and out when family members forgot. Staff persons kept a "running tally" of how many children were present for each classroom. The plan also stated that there was a "large climber" on the preschool playground that was only appropriate for children five years of age and older. Children younger than five years of age "should not play" on playground equipment that is not "age appropriate" for them.

The facility's *Staff Policies and Employee Handbook* stated that staff persons were to count children when they left one area and when they arrived at the new area. Staff persons kept a written list of children in their care and in the app so they could cross reference the numbers. The app had a name to face option that allowed staff persons to do a name to face check to ensure that they had all the children. Staff persons' personal cell phone use was permitted for using the app.

Facility documentation showed that the P, SP1, and SP2 each received training on the facility's *Risk Reduction Plan, Staff Policies and Employee Handbook*, and the Reporting of Maltreatment of Minors Act prior to the incident.

Relevant Rules and Statutes:

Minnesota Statutes, section 142B.01, subdivision 27 and Minnesota Rules, part 9503.0045, subpart 1, item A, state that "supervision" means 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; and that children are required to be supervised at all times.

Conclusion:

A. Maltreatment:

Consistent information was provided that on May 5, 2025, SP1, SP2, and the Preschool 1 children, including the AV, were on the playground. At approximately 8:45 a.m., SP1 and SP2 lined the children up (including the AV) along the fence inside the playground. SP1 and SP2 each stated they looked at the *Transition/Combining Checklist* to know how many children were present, counted 16 children in line in the playground, led the group out of the playground, walked the children across the parking lot and then into the stairwell that led down to the classroom. SP1 stated s/he counted the children as they entered the stairwell and SP2 stated s/he counted the children once they were inside the stairwell.

SP1 and SP2 then led the children to the classroom. When SP1 and SP2 entered the classroom, each stated they assisted children as they used the bathroom and washed their hands for breakfast. Neither SP1 nor SP2 completed a headcount of the children immediately after entering the classroom, which was inconsistent with the facility's policies and with their training. At least 15 and up to 45 minutes later, SP1 completed the *p chart* and checked the AV in, but noticed the number of children on the chart did not match the number of children in the classroom. SP2 noticed that SP1 had checked the AV on the *p chart*, but the AV was not in the classroom. SP1 went to the playground and found the AV unsupervised on the preschool playground approximately ten feet from the open playground gate.

The AV was unsupervised between 15 and 45 minutes, which was a violation of Minnesota Statutes 142B.01, subdivision 27, and Minnesota Rules, part 9503.005, subpart 1, item A. The AV was not harmed. However, given that the AV was under four years old; the playground gate was open; the AV was visible to passersby; the location of the playground exposed the AV to community persons, vehicle traffic and other hazards; the AV had access to playground equipment that was not age appropriate; and that the AV was unsupervised in these conditions for at least 15 minutes; there was a preponderance of the evidence that there was a failure to protect the AV from conditions that seriously endangered his/her physical or mental health when reasonably able to do so, and that there was a failure to supply the AV with necessary care.

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):

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.

SP1 and SP2 each said they did not receive sufficient training on transitions. In addition, information was

consistent that the number of children marked present on both the Brightwheel app and the paper *Transition/Combining Checklist* was incorrect. However, facility documentation showed that SP1 and SP2 were each trained on the Reporting of Maltreatment of Minors Act and on the facility's policies, including those regarding the supervision of children, prior to the incident; and neither SP1 nor SP2 made efforts to ensure that the children were all accounted for upon return to the classroom until 15 to 45 minutes after reentering the classroom. SP1 and SP2 were each responsible for the care and supervision of the AV at the time of the incident were each determined responsible for the 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 determined that their policies were adequate but not followed by SP1 and SP2. SP1 and SP2 each received performance management from the facility regarding the incident.

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 SP1 and SP2 were each determined responsible for maltreatment. The determination that SP1 and SP2 were each responsible for maltreatment is subject to appeal.

On October 31, 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 Children, Youth, and Families.