

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: 202504155

Date Issued: October 30, 2025

Name and Address of Facility Investigated:

KinderCare Learning Center
17701 Excelsior Blvd.
Minnetonka, MN 55345

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

License Number and Program Type:

801289-CCC (Child Care Center)

Investigator(s):

Tessa Ripka
Minnesota Department of Children, Youth, and Families
Office of Inspector General, Licensing Division
PO Box 64242
Saint Paul, Minnesota 55164-0242
tessa.ripka@state.mn.us
651-539-8261

Suspected Maltreatment Reported:

It was reported that a staff person (SP) forcefully grabbed and swung an alleged victim (AV) up in the air resulting in a bruise on the AV's arm.

Date of Incident(s): May 14, 2025

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 May 29, 2025; from documentation at the facility; and through three interviews conducted with three facility staff persons (P1, P2, and the SP), including a supervisory staff person. P1 was also the AV's family member.

The facility was a large building with classrooms along each side. The playground ran along one side of the building. The infant classroom windows looked out onto the playground.

The AV was 22 months old at the time of the incident and enrolled in a toddler classroom. Due to the AV's age s/he was not able to provide information about the incident.

P1 provided the following information:

- P1 said that on an unspecified date, s/he was in the infant classroom. The AV was outside with his/her classroom. The AV came to the window of the infant classroom and was crying because the AV knew P1 was in that classroom. The SP came up to the AV and grabbed the AV by the wrist, picking the AV up into the air and holding the AV's arm up so high that his/her shoulder bone stuck out. The SP took his/her other hand and "swung" the AV onto the SP's side holding the AV's stomach. The SP left the view of the window so P1 was not able to see what happened after that. P1 did not think the SP was aware that P1 was watching through the window.
- P1 took the AV home for the day at approximately 5 p.m. At that time, P1 and another family member noticed a bruise on the AV's wrist. The bruise was not there when the AV was taken to the facility that morning. The bruise looked like a "big thumb" print in the middle of the AV's wrist and was blue/purple. The AV held his/her arm/wrist at times during the rest of the day.

P2 provided the following information:

- P2 said that on May 14, 2025, P1 said that s/he had seen the AV crying outside and then the SP picked the AV up by the arm and carried the AV away. P2 talked with the SP about picking children up safely. The next morning, P2 found out that AV had a bruise on his/her arm. P2 asked the SP to come in and fill out a statement, but the SP got upset, yelled at P1 and P2, and then left the facility.
- P2 said the AV's bruise was dark in color on the right forearm, wrapping around the arm. There were a couple spots that could indicate fingers. P2 did not have any previous concerns with the SP, but noted the SP did have a "very firm and loud" voice.

The SP provided the following information:

- On an unspecified date, the SP was outside on the playground and the AV was crying and screaming by the infant classroom windows because P1 worked in that classroom. The AV cried for a "long time," so the SP went over and took the AV's hand "gently" and took the AV back to the play area.

- The SP believed that staff persons made up the allegation because they did not want the SP to have more hours. The SP also believed that the bruise was done with markers and said that s/he did not see any bruising on the AV on the day of the incident. There were other staff persons on the playground who saw the incident, but the SP could not recall the names of the staff persons. When asked by the facility, the SP declined to write an explanation letter.

A photo of the AV taken on May 15, 2025, showed a light bruise on the AV's right forearm. The bruise was in the middle of the top of forearm and was darker than the AV's skin tone. It appeared to be two or more round spots.

The facility's *Behavior Guidance Plan for Staff* stated that staff persons modeled and reinforced appropriate behavior. Staff persons did not use corporal punishment, physical or manual restraints, emotional punishments, or punishment for lapses in toilet training; and did not withhold food, light, warmth, clothing, or medical care.

Facility documentation showed that staff persons were trained on the facility's policies and the Reporting of Maltreatment of Minors Act.

Law enforcement did not investigate this incident.

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:

On May 14, 2025, P1 saw the SP pick up the AV by the wrist and swing the AV up onto the SP's side. P2 was notified and talked with the SP about picking up children in a safe manner. Later that day, P1 noticed bruising on the AV's forearm/wrist area. When asked to write up a statement the following day the SP got upset, yelled at P1 and P2, and left the facility.

The SP said that s/he took the AV's hand and "gently" took the AV back to the playground. The SP said that the allegations were not true and were made up because the facility did not want to give the SP more hours. The SP also said s/he thought the AV was not injured but an image of a bruise was drawn on the AV with markers. However, a photo of the AV's arm taken on May 15, 2025, showed that the AV had a light bruise on the top of his/her forearm that was consistent with being lifted by his/her forearm.

Although the SP said that s/he took the AV's hand gently, given that P1 said the SP picked the AV up off the ground by his/her wrist and swung the AV to the SP's waist, that the AV had bruising that was consistent with being lifted by the forearm, that the SP had reason to minimize his/her actions, and that there was no information that the AV sustained the injury by any other means, it was likely the incident occurred as described by P1. The SP's actions of lifting the AV off the ground by his/her wrist was inconsistent with the standards of a professional caregiver in a facility licensed by the Department of Children Youth and Families; a violation of the facility's

policies; and a violation of Minnesota Rules 9503.0055, subpart 3, item A. Given the aforementioned there was a preponderance of the evidence that a physical injury was inflicted on the AV other than by accidental means.

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):

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.

Facility documentation showed that the SP received training on the facility's policies and the Reporting of Maltreatment of Minors Act prior to the incident.

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 determined that policies and procedures were adequate but not followed. 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 was responsible for maltreatment is subject to appeal.

On October 30, 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.