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: 202201269 and 202201993

Date Issued: April 29, 2022

Name and Address of Facility Investigated:

Pine Pals Intergenerational Learning Child Care and Preschool
1700 30th Street NW
Bemidji, MN 56601

Disposition: Allegation one: Maltreatment not determined.
Allegation two: Maltreatment determined as to neglect of an alleged victim by two staff persons.

License Number and Program Type:

1106266-CCC (Child Care Center)

Investigator(s):

Rebecca Mesto
Minnesota Department of Human Services
Office of Inspector General
Licensing Division
PO Box 64242
Saint Paul, Minnesota 55164-0242
651-431-6558

Suspected Maltreatment Reported:

Allegation one: It was reported that on February 15, 2022, two alleged victims (AV1 and AV2) each left the toddler group during a transition from their classrooms to an indoor play room at the facility. AV1 was found unsupervised in the facility's lobby and AV2 was found unsupervised outside by another child's family member (CFM1). The two staff persons (SP1 and SP2) were not aware AV2 was missing.

Allegation two: During the initial investigation, it was also reported that on March 15, 2022, an alleged victim (AV3) was found, unsupervised, in an unoccupied preschool classroom, for ten minutes, without staff person knowledge.

Date of Incident(s): February 15 and March 15, 2022

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 March 2, 2022; from documentation at the facility; and through ten interviews conducted with an administrative staff person (SP1), four facility staff persons (P1, P2, SP2, and SP3), a family member (FM1) of AV1, two family members (FM2 and FM3) of AV2, a family member (FM4) of AV3, and CFM1. Due to the ages of the alleged victims, they were not interviewed for this investigation.

The facility was located in a two level building, attached to an assisted living facility. The facility's main entrance led into a large foyer with two doors, one of which led to the facility and the other to the assisted living facility. There were accessibility buttons that could be used to open each of the doors, including the door leading outside, which led to a parking lot and an adjacent road. There were other businesses and residential houses near the facility. Upon entering the facility, there was a large lobby with a desk and a hallway leading to offices, several infant classrooms, an indoor play room, and a cafeteria. There was an elevator located on one side of the hallway, approximately ten feet from the play room. The play room's entrance was a double door at the end of the main hallway. The play room was a large room with padded floors and large climbing structures and equipment for the children to utilize. The main hallway turned to the right, toward a cafeteria. Near the elevator was a door to a stairway which led upstairs where there was a long hallway with several doors leading to various toddler and preschool classrooms, including the Toddler A and B rooms and the Preschool A room. Preschool A was closer to the stairway door and was located on the opposite side of the hallway from Toddler B.

The facility's *Risk Reduction Plan* stated that during transitions, children were to be supervised at all times. Staff persons were to know the number of children and the location of each child at all times. When using the elevator, staff persons were to watch the door closely.

Facility documentation showed that each staff person interviewed for this investigation received training on the facility's policies and the Reporting of Maltreatment of Minors Act.

Relevant Rules and/or Statutes:

Minnesota Rules, part 9503.0045, subpart 1, item A, states that children are required to have supervision at all times. Minnesota Statute section 245A.02, subdivision 18, states that supervision means 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.

Allegation one: *It was reported that on February 15, 2022, AV1 and AV2 each left the toddler group during a transition from their classrooms to the indoor play room at the facility. AV1 was found unsupervised in the*

facility's lobby and AV2 was found unsupervised outside by CFM1. SP1 and SP2 were not aware AV2 was missing.

AV1 was 34 months old and enrolled in the facility's Toddler B room. AV2 was 23 months old and enrolled in the facility's Toddler A room.

The facility had video cameras in some areas, including the foyer, and this investigator was able to view footage of the foyer from the afternoon of February 15, 2022. The video showed the following:

- At 4:30 p.m., AV2 entered the foyer from the facility. AV2 pushed the accessibility button and opened the outside door and stood next to the door, looking outside. During the next three minutes, AV2 opened the outer door several times and sometimes looked out the door, waiting for it to automatically close. AV2 also pushed a wheelchair that was in the foyer, touched a statue of a snowman, and pushed the accessibility button leading to the assisted living facility. Due to the location of the camera, it was unknown if this door opened or not.

- Approximately three and a half minutes after AV2 entered the foyer, CFM1 entered the foyer from outside and then two other people (CFM2 and CFM3) followed him/her inside. For the next minute, they appeared to talk to AV2 and to each other, then led AV2 into the door to the facility.

CFM1 stated that on the day of the incident, s/he came to the facility to pick up a family member from the facility and saw AV2 in the foyer, pushing a wheelchair. AV2 did not have any shoes on. CFM1 brought AV2 into the facility, knocked on an infant room door, and informed a staff person that s/he had found him/her in the foyer but did not know where s/he belonged. Then that staff person took AV2 to his/her group.

The facility's *Incident Report from Pine Pals* stated that on February 15, 2022, at approximately 4:30 p.m., SP1 and SP2 took fourteen toddlers, including AV1 and AV2, from the toddler rooms, downstairs in the elevator, to go to the play room. When the elevator door opened, some of the children exited on their own. SP1 saw "some" of the children walk toward the cafeteria and redirected them to the play room while SP2 guided the other children into the play room. SP1 told SP2 that s/he was unable to count the children and was unsure if all of the children were accounted for. SP1 then noticed that AV1 was not in the play room, so SP2 went into the lobby, found AV1, and
brought him/her into the play room. Five minutes later, CFM1 brought AV2 into the play room and said that s/he had "gotten outside." AV2 was uninjured and joined the group.

P1, SP1, and SP2 provided the following information:

- On the day of the incident, shortly before 4:30 p.m., SP1 joined SP2 in one of the toddler rooms after another staff person finished their shift. There were fourteen toddlers combined from the Toddler A and B rooms.

- SP2 stated that before leaving the classroom, s/he counted the children and then s/he and SP1 took the children into the elevator. When the elevator door opened on the first floor, SP1 and SP2 each stated that the children began leaving the elevator before SP1 and SP2 were able to lead them to the play room, and the children went in various directions.
  SP2 stated that s/he went down the hallway to get AV1 from the lobby and SP1 went toward the cafeteria

to gather other children to bring them into the play room. SP1 and SP2 each brought children into the play room. SP2 stated that s/he did not have time to count the children before P1 brought AV2 into the playroom and told them that s/he was found outside.

- SP1 stated that s/he counted the children on the elevator. SP2 stood against the elevator door, to ensure children would not get caught in the door when it closed and when the elevator door opened, the children went out. SP1 first went to the play room and then saw some children had walked toward the cafeteria so s/he gathered them and brought them into the play room. SP2 was already in the play room and SP1 told SP2 that s/he had not had a chance to count the children and then attempted to count them, but they were actively moving around, playing. SP1 noticed that AV1 was missing, so SP2 went into the lobby and brought AV1 into the play room. SP1 tried to count the children again and then P1 brought AV2 into the playroom.

- P1 stated that s/he was working in an infant room when CFM1 opened the infant room door and said s/he found AV2 outside and asked if s/he belonged at the facility. AV2 was "fine" and P1 took AV2's hand and walked down the hallway where s/he heard children in the play room. They walked into the play room and saw SP1 was standing with a group of toddlers and SP2 was sitting on the floor with a child on his/her lap. P1 stated that it appeared that they had just entered the play room because the children were next to SP1 and SP2.

- SP2 stated that AV1 and AV2 had each run from the group previously, but staff persons had always been able to follow them and bring them back to the group.

- SP1 stated that s/he had been filling in as needed in various classrooms in the evening, but was not typically in the toddler rooms.

- SP1 and SP2 each stated that children were never to be left alone and were to be supervised by sight and hearing.

FM1 stated that AV1 had left the toddler group on "multiple" occasions previously and staff persons did not "notice" for a "couple" minutes.

FM2 and FM3 were each concerned that AV2 was unsupervised, but had not had prior concerns regarding the care AV2 received at the center.

Conclusion for Allegation One:

On the afternoon of February 15, 2022, during a transition from the toddler rooms upstairs to the indoor play room on the main floor, several children left the elevator before SP1 and SP2 could gather them all into the play room. SP2 found AV1, unsupervised, in the lobby and AV2 was found by CFM1 in the foyer. AV1 and AV2 being unsupervised was a violation of Minnesota Rules, part 9503.0045, subpart 1, item A and Minnesota Statute section 245A.02, subdivision 18.

SP1 and SP2 provided consistent information that when the elevator door opened, the children went in various directions. SP1 and SP2 attempted to gather the children to bring them into the play room and SP1 noticed that

AV1 was missing, so SP2 went to look for AV1 and found him/her in the lobby. SP1 stated that s/he attempted to count the children after AV1 was returned, but SP1 and SP2 were not able to count the children in the playroom before AV2 was found by CFM1 and brought to the play room.

AV1 was found by SP2 after it was determined that AV1 was not in the group. The children were counted before they left the classroom and while in the elevator, and although SP1 and SP2 were not aware AV2 was in the foyer, they were in the process of accounting for all of the children in their group at the time CFM1 found AV2. Given that staff persons followed their procedures by counting children at times of transition and were actively attempting to account for all the children at the time, there was not a preponderance of the evidence that there was a failure to protect the children from conditions or actions that seriously endangered the children's physical or mental health.

It was not 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. 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).

Allegation two: *During the initial investigation, it was also reported that on March 15, 2022, AV3 was found, unsupervised, in an unoccupied preschool classroom, for ten minutes, without staff person knowledge.*

AV3 was 26 months old and was enrolled in the Toddler B room.

The Preschool A room was a square shaped room with tables, chairs, and play equipment which was appropriate for preschool aged children (32 months and up). There were containers located on shelving accessible for children which contained small toys and art supplies such as legos, small beads, cotton balls, blunt scissors, and one inch foam letters.

According to the *Daily Sign In-Out Report*, at the time of the incident, there were nine children in the Toddler B room.

P2 provided the following information:

- Mid-morning on March 15, 2022, P2 and another staff person were in the Toddler A room, getting children ready to go outside. P2 heard the Toddler B group in the hallway and then approximately 10 to 15 minutes later, P2 opened the Toddler A room door and two children ran to the Preschool A room and looked in. P2 followed them and saw AV3 alone, by the window, playing with trains. AV3 was dressed to go outside. P2 brought AV3 into the Toddler A room and when all of the Toddler A children were dressed to go outside, P2 and another staff person brought the children and AV3 outside to the playground. When they arrived on the playground, P2 told SP2 that s/he found AV3 in a preschool room. SP2 and SP3 were each not aware AV3 had been missing.

- P2 did not tell administrative staff persons about the incident right away, but instead sent a group email out to the staff, including SP1, asking for classroom doors to be closed when they were not in the rooms. Two days later, an administrative staff person, who was not included in the email, asked P2 about the incident.

- P2 stated that staff persons were to count children "all the time" to ensure all of the children were in attendance. P2 said that in the past, children ran away from staff persons when they were in the hallway, but staff persons were always following them.

- P2 was not concerned with the way SP2 and SP3 supervised children, but noted that children seemed to "walk all over" them.

SP2 and SP3 provided the following information:

- On the day of the incident, SP2 and SP3 were in the Toddler B room, getting the children ready to go outside. SP3 stated that s/he counted the children before they left the room, then led the children down the hallway towards the stairway. SP2 was at the end of the line. When SP3 got to the door to the stairway, s/he stopped and asked SP2 if they had all of the children. SP2 said they had everyone. SP3 opened the door to the stairway and led the children downstairs then asked SP2 again if they had everyone and SP2 replied yes. Then SP3 led the children onto the playground and SP2 followed. Five minutes after they arrived on the playground, another toddler staff person (P2) told SP2 and SP3 that s/he found AV3 in a preschool room, playing with toys. AV3 was uninjured.

- SP2 stated that after s/he and SP3 got the children ready to go outside, SP2 counted the children by counting to him/herself. SP2 was not aware if SP3 counted the children. AV3 was in line with the rest of the children and when the door was opened, SP3 led the line of children down the hallway. SP2 stated that it was a "hectic" morning and s/he had to carry one child down the hallway. They walked down the stairs and out to the playground. SP2 did not see AV3 leave the group or enter the preschool room and was not aware s/he was missing until P2 told him/her that AV3 was found in a preschool room. SP2 did not count the children on the playground.

- SP3 stated that s/he had counted the children earlier that day, but did not count the children before they left the classroom and was not aware if SP2 counted the children. SP3 recalled seeing AV3 in line with the other children before they left the classroom. SP3 did not count the children when they arrived on the playground, but thought that since SP2 was walking at the back of the line and said all of the children were there, that all were accounted for.

- SP3 stated that s/he did not typically work in the Toddler B room. SP3 did not have any concerns with the way SP2 supervised the children. SP2 did not have any concern with how SP3 supervised the children.

- SP2 and SP3 each stated that children were never to be left unattended and they were to be within sight and hearing of a staff person. SP2 and SP3 each stated that they typically counted the children throughout the day.

- SP1 was not aware of the incident until s/he read P2's email on March 16, 2022. The next day, s/he talked to staff persons about not leaving doors open and informed another administrative staff person about the

  incident. SP1 was not concerned with how SP3 supervised the children. After the second incident, SP1 was concerned with how SP2 supervised children.

FM4 stated that s/he was concerned that s/he was not told about the incident until days after and not on the day of the incident. AV3 was a "climber" and if unsupervised, may have fallen, gotten injured, or swallowed something.

Conclusion for Allegation Two:

A. Maltreatment:

On March 15, 2022, during a transition from the Toddler B room to the playground, AV3 left the group and was found in an unoccupied preschool room by P2, approximately 10 to 15 minutes later. SP2 and SP3 were not aware AV3 was missing. AV3 being unsupervised was a violation of Minnesota Rules, part 9503.0045, subpart 1, item A and Minnesota Statute section 245A.02, subdivision 18.

SP2 stated that s/he counted the children as they were in line in the classroom before leaving for the playground. SP2 and SP3 provided consistent information that SP3 led the group of children in the hallway and SP2 followed at the end, but SP2 did not see AV3 leave the group. SP3 stated that s/he stopped at the door to the stairway and asked SP2 if all of the children were accounted for and SP2 said that they were all there. SP2 and SP3 each said that neither counted the children after they arrived on the playground.

On March 15, 2022, AV3 was in a preschool room, unsupervised, for 10 to 15 minutes. Given that AV3 was able to access the preschool room and toys and equipment that were not intended for use by someone AV3's age, that it was unlikely that AV3 would be able to exercise self-preservation skills in the event of an emergency, that no staff person was aware that AV3 was unsupervised in an area not designed for access by AV3, and that SP2 and SP3 each stated that they each did not count the children upon arriving on the playground and were therefore unaware that AV3 was missing from the group, there was a preponderance of the evidence that there was a failure to provide AV3 with care necessary to maintain his/her 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. 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.

SP2 and SP3 were each trained on the Reporting of Maltreatment of Minors Act and on the facility's policies prior to the incident.

When SP2 and SP3 left the Toddler B room, SP3 led the group of toddlers in the hallway and SP2 followed behind. SP3 stated that s/he stopped twice and asked SP2 if all of the children were in the group, and SP2 replied that they were all in attendance each time. Neither SP2 nor SP3 counted the children on the playground to ensure each child was there, so therefore SP2 and SP3 were each responsible for maltreatment of AV3.

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 SP2 and SP3 were responsible did not meet statutory criteria to be determined as recurring because it was a single event and it was not serious because AV3 did not require medical care.

Action Taken by Facility:

The facility completed two internal reviews and determined that for the first incident, their policies and procedures were adequate but not followed when staff persons did not lead the children to the play room and did not follow up to ensure all the children arrived at the play room. Staff persons were to review the *Risk Reduction Plan* and other policies regarding supervision. The "team" discussed strategies to help prevent children from using the accessibility button, leaving the building, and different ways of transitioning, etc.

For the second incident, the facility determined that their policies and procedures was not adequate and updated their *Risk Reduction Plan* to include a transition tracking chart for staff persons to count the children and initial when they leave an area and when they arrive to their destination. Their policies and procedures were not followed when staff persons did not count children after they arrived to the playground. All staff persons were to be retrained on the *Risk Reduction Plan, Emergency and Accident Policies, Supervision Policies,* and the use of the newly created *Transition Tracking Chart*.

Action Taken by Department of Human Services, Office of Inspector General:

SP2 and SP3 were each not disqualified from providing direct care services as a result of the maltreatment determination in this report. However, SP2 and SP3 were each 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 the disqualification of SP2 and SP3. The determination that SP2 and SP3 were each responsible for maltreatment is subject to appeal.

On April 29, 2022, 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 Human Services.