

STATE OF MINNESOTA
OFFICE OF ADMINISTRATIVE HEARINGS
FOR THE DEPARTMENT OF HUMAN SERVICES

In the Matter of the Appeal of
Kids Inc. - North

**FINDINGS OF FACT,
CONCLUSIONS AND
RECOMMENDATION**

A hearing was held on September 30, 2011, at the Office of Administrative Hearings by Administrative Law Judge Beverly Jones Heydinger, pursuant to a Notice and Order for Prehearing Conference and Hearing dated February 21, 2011, to consider the appeal by Kids Inc. - North of the Determination of Maltreatment and Order to Forfeit A Fine issued by the Department of Human Services on September 10, 2010.

The hearing record closed upon the completion of the hearing on September 30, 2011.

Appearances: Matthew D. Schwandt, Assistant Attorney General, on behalf of the Department of Human Services (Department). Mary Anderson, President, and Randy Anderson, Vice President, appeared on behalf of Kids Inc. – North (Respondent), without benefit of counsel.

STATEMENT OF THE ISSUES

1. Was the Respondent responsible for maltreatment of a child, pursuant to Minn. Stat. §§ 245A.02, subd. 18, and 626.556, subd. 2, and Minn. R. 9503.0045, subp. 1 (A)?¹

2. If the Respondent was responsible for maltreatment, did the Department properly impose a fine of \$1,000, pursuant to Minn. Stat. § 245A.07, subd. 3?

The Administrative Law Judge concludes that the maltreatment occurred and the penalty should be affirmed.

Based on the evidence in the hearing record, the Administrative Law Judge makes the following:

¹ Minnesota Statutes are cited to the 2010 Edition; Minnesota Rules are cited to the 2011 Edition.

FINDINGS OF FACT

1. Kids Inc. – North, located in Hutchinson, Minnesota, is licensed as a child care facility. Mary E. Anderson is the President; Randy Anderson is the Vice-President.

2. On May 4, 2010, a two-and-a-half-year-old boy, C.B. awoke from his nap at the facility. B.A., the preschool aide in charge of the room where C.B. had been napping, directed C.B. to place his blanket in a storage bin (a “cubby” or “bucket”) and join the other children in a nearby room, the preschool lunchroom and activity room, for a snack. Another staff member, D.S., was supervising the children in the lunchroom. The facility director, K.S.-N., was also at the facility but was in the basement at the time.²

3. The main entrance of the facility opens into a large preschool classroom. A doorway on the left end of the classroom opened into the preschool nap room; a door across from the entrance opens into the preschool lunchroom. Both the room where C.B. was napping and the lunchroom have short gates at the entrance. The staff office is located next to the lunchroom. The children’s storage bins was arranged in a “U” shape between the entrance and the door to the staff office.³

4. C.B. did not go to the lunchroom; he walked out the front door of the facility. The door was not locked and opened on to a parking lot, separated from the street by a sidewalk. The Facility is located on a residential street with a speed limit of 30 miles per hour.⁴

5. A person driving by saw C.B. outside the facility, stopped and brought him back to the door, checking to see that he belonged at the facility. C.B. was outside the building for approximately one to five minutes.⁵

6. The staff checked to make sure that C.B. was not harmed and notified the director. At the end of the day, C.B.’s mother was notified.⁶

7. C.B. lives next door to the facility.⁷ He frequently plays at the facility when he is not attending daycare.⁸

8. The Respondent’s policy was that a staff member should hand off a child to another staff member. In this case, the staff member in the nap room should have watched the child until the lunchroom staff member took charge. When interviewed,

² Ex. 5.

³ Ex. 5 at DHS 18; Exs. 11-12.

⁴ Ex. 5.

⁵ Ex. 5.

⁶ Ex. 5.

⁷ Ex. 5 at DHS 20; Ex. 9 at DHS 55.

⁸ Testimony of Mary Anderson.

D.S. and K.S.-N. were not certain that B.A. had been carefully instructed to watch each child until the child was safely in the preschool lunchroom.⁹

9. At the time of the incident, B.A. had been working at the facility for about four months. She frequently worked in other rooms (with infants and toddlers) and had worked with C.B. just a few times previously.¹⁰ She reported that the staff had reviewed with her the Respondent's policies, including supervision of the children, when she was hired. She had also read the employee handbook.¹¹

10. B.A. had worked in the nap room a few times before. Sometimes three staff members were present and one stood in the large classroom to watch the children move between the nap room and lunchroom. At the time of the incident, a third staff member was not observing.¹²

11. The Respondent has a six-month probation period. At the end of probation, each staff member is expected to be completely familiar with all of the facility's policies and procedures.¹³

12. The Caregiver Procedure Handbook dated May 2010 included a section addressing supervision of children when going out-of-doors or on field trips. It stated: "Supervision is when the children are in the sight and hearing of a staff member."¹⁴ There is no section specifically addressing supervision inside the facility or near the main entrance.

13. The incident was reported to DHS licensing staff on May 10, 2010. By that date, the facility's director had met with B.A., reviewed the safety and supervision policies with her, reminded all other staff of the policies, and installed a door chime to ring when the main entrance door opened.¹⁵

14. The Department is responsible for investigating allegations of neglect in child care facilities.¹⁶ Alice Percy was the assigned licensing investigator. She has conducted licensing investigations for the Department for more than six years and previously was the director of a child care center and a teacher.¹⁷

⁹ Ex. 5 at DHS 19-20 Ex. 7 at DHS 43 (K.S.-N.); Ex. 8 at DHS 49 (D.S.).

¹⁰ Ex. 7 at DHS 43 (K. S.-N.);

¹¹ Ex. 5 at DHS 20; Ex. 9 at DHS 55; Ex. 17 at DHS 127-130.

¹² Ex. 8 at DHS 49-50 (D.S.).

¹³ Ex. 14 at DHS 83.

¹⁴ Ex. 14 at DHS 97. See *also* Ex. 16 (Preschool Staff Information) at DHS 136.

¹⁵ Exs. 1 and 2.

¹⁶ Minn. Stat. § 626.556, subd. 2 (i), subd. 3c (b) and subd. 10b.

¹⁷ Test. of Alice Percy.

15. As part of her investigation, Ms. Percy visited the facility, took photos and interviewed the staff who had knowledge of C.B. leaving the facility.¹⁸ The facility's staff fully cooperated with the investigation.¹⁹

16. Child care centers must appropriately supervise the children in care. "Supervision" means "a program staff person is within sight and hearing of a child at all times so that the program staff can intervene to protect the health and safety of the child."²⁰

17. The child care program must have a plan that mandates that children have supervision at all times, and the license holder must see that the plan is carried out.²¹

18. For the purposes of determining maltreatment of minors, "neglect" is defined in relevant part as:

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...;²²

19. Ms. Percy found that the Respondent was responsible for caring for and supervising C.B. She also found that, in light of C.B.'s age and because he left the facility without the staff's knowledge and was placed at serious risk when he entered an unprotected parking area near the street, the Respondent failed to protect C.B. from conditions that endangered his health. Based on these findings, Ms. Percy concluded that maltreatment occurred.²³

20. When maltreatment is determined in an investigation involving a facility, the Department must also determine whether the facility or an individual was responsible, or whether both the facility and the individual were responsible for the maltreatment, applying mitigating factors set forth in the law.²⁴ This includes:

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

¹⁸ Test. of A. Percy; Ex. 5.

¹⁹ Test. of A. Percy.

²⁰ Minn. Stat. § 245A.02, subd. 18.

²¹ Minn. R. 9503.0045, subp. 1 A.

²² Minn. Stat. § 626.556, subp. 2 (f).

²³ Ex. 5 at DHS 21; Test. of A. Percy.

²⁴ Minn. Stat. § 626.556, subp. 10e (e) and (i).

caregiver's supervision, and facility staffing levels and the scope of the individual employee's authority and discretion.²⁵

21. The Department concluded, based on the evidence as a whole, that the facility and not the individual should be responsible for the maltreatment because of the lack of evidence that B.A. had received proper training about supervising the children as they moved between rooms in proximity to an unlocked entrance. The Respondent's training materials did not specifically address supervision in the facility, and neither the teacher nor the director was certain that they had told B.A. to be sure that children were watched as they moved from the nap room to the lunchroom. Following the incident, in addition to installing the door chime, the Respondent revised its policies and procedures.²⁶

22. Pursuant to Minn. Stat. § 245A.07, subd. 3 (c)(4), the Department shall order a license holder to forfeit a fine of \$1000 for each determination of maltreatment of a child for which the license holder is determined responsible.

23. The Department ordered the Respondent to forfeit a fine of \$1000 based on its determination that maltreatment occurred for which the facility was responsible.²⁷

24. The Determination of Maltreatment and Order to Forfeit a Fine is dated September 10, 2010, but the date it was mailed to Respondent is not clear from the record. The Respondent's president, Ms. Anderson, was concerned that parents of the children in care received notice of the action before Respondent received its notice.²⁸ Ordinarily, the Department sends notice to the parents a few days after the facility is notified,²⁹ but the dates of the notices given here were not established. The Respondent's request for a contested case hearing was dated September 22, 2011.³⁰

25. Ms. Anderson emphasized the facility's long record of providing excellent child care. For 21 years, no incident involving inadequate supervision occurred. Ms. Anderson explained the clear procedures in place, staff training and attention to detail, the concern for the safety and welfare of the children, and the facility's prompt corrections and installation of the door chime to prevent any reoccurrence. She also reported that the incident was "devastating" to the staff who held themselves responsible and fully understood the serious risk of harm to C.B. She requested that the fine be rescinded because of the years of fine performance and the blemish that a maltreatment finding would be on an exemplary record and hard-earned reputation.³¹

26. Mr. and Ms. Anderson believed that the staff's statements that B.A. may not have been fully trained were made to protect B.A. who was still in her probationary

²⁵ Minn. Stat. § 626.556, subp. 10e (i)(2).

²⁶ Ex. 5 at DHS 21-22; Ex. 20; Test. of A. Percy.

²⁷ Ex. 20.

²⁸ Test. of M. Anderson.

²⁹ Test. of A. Percy.

³⁰ Ex. 21.

³¹ Ex. 21; Test. of M. Anderson; Test. of R. Anderson.

period. The staff did not want B.A. to get in trouble because she was young and a good person and caregiver. Also, the staff was very upset by what happened and were questioning whether there was anything that they could have done to prevent it. The director offered to resign and, although B.A. had been getting a degree in early childhood education, this incident caused her to give up her pursuit of a career in education. The Andersons believed that the staff training was thorough and directly focused on the safety of the children, and included directions to watch the children move from one room to another. Neither one underestimated the seriousness of the incident, but in light of their record and prompt actions to assure that no similar incident would occur, they believe that a warning should suffice, or that a \$200 fine for failure to comply with the Department's supervision rule would be a more appropriate sanction.

27. Mr. and Ms. Anderson also objected to an article in the *Star Tribune* on May 29, 2011, reporting the Respondent's maltreatment of a child while the Respondent's appeal was pending. The article led to many calls, it was posted in a school lunchroom, and many people, including some parents, believed that another maltreatment determination had been made because of the time since the Department's order had been issued in September 2010.

Based on these Findings of Fact, the Administrative Law Judge makes the following:

CONCLUSIONS

1. The Department and the Administrative Law Judge have jurisdiction to consider this matter pursuant to Minn. Stat. §§ 14.50, 245A.07, subd. 3, and 245A.08, subd. 2a (f) (1).

2. The Respondent received proper and timely notice of the hearing and the Department complied with all procedural requirements.

3. The Department has demonstrated by a preponderance of the evidence that the Respondent committed maltreatment, in violation of Minn. Stat. § 626.556, subd. 2 (f), when it failed to properly supervise a child in its care and to protect a child from conditions or actions that seriously endangered the child's physical health when reasonably able to do so.

4. The Department demonstrated by a preponderance of the evidence that, pursuant to Minn. Stat. § 626.556, subp. 2 (q), the facility is responsible for the maltreatment for failing to assure that its staff was fully trained and failing to take precautions so that a child would not leave the facility through an unlocked entrance, and, pursuant to Minn. Stat. § 245A.07, subd. 3 (c)(4), that a fine of \$1,000 should be imposed.

5. Any Findings of Fact more properly designated as Conclusions are hereby adopted as such.

Based upon these Conclusions, and for the reasons explained in the accompanying Memorandum incorporated herein, the Administrative Law Judge makes the following:

RECOMMENDATION

The Administrative Law Judge recommends that the Department's determination of maltreatment and assessment of a \$1,000 fine be AFFIRMED.

Dated: October 21, 2011

s/Beverly Jones Heydinger
BEVERLY JONES HEYDINGER
Administrative Law Judge

Reported: Digitally Recorded

NOTICE

This report is a recommendation, not a final decision. The Commissioner will make the final decision after a review of the record. The Commissioner may adopt, reject or modify these Findings of Fact, Conclusions, and Recommendations. Under Minn. Stat. § 14.61, the Commissioner shall not make a final decision until this Report has been made available to the parties for at least ten calendar days. The parties may file exceptions to this Report and the Commissioner must consider the exceptions in making a final decision. The Commissioner then has 10 working days to issue his final decision. Parties should contact Lucinda Jesson, Commissioner of Human Services, PO Box 64998, St. Paul, MN 55164-0998, (651) 431-2907, to learn the procedure for filing exceptions or presenting argument.

If the Commissioner fails to issue a final decision within 90 days of the close of the record, this report will constitute the final agency decision under Minn. Stat. § 14.62, subd. 2a. In order to comply with this statute, the Commissioner must then return the record to the Administrative Law Judge within ten working days to allow the Judge to determine the discipline or sanction to be imposed. The record closes upon the filing of exceptions to the report and the presentation of argument to the Commissioner, or upon expiration of the deadline for doing so. The Commissioner must notify the parties and the Administrative law Judge of the date on which the record closes.

Under Minn. Stat. § 14.62, subd. 1, the agency is required to serve its final decision upon each party and the Administrative Law Judge by first class mail or as otherwise provided by law.

MEMORANDUM

The Respondent does not dispute that a child left the facility and was found by a person passing by. Its owners and staff are well aware of the danger to the child and the seriousness of the incident. Nonetheless, the Respondent asks that the maltreatment determination be rescinded because of the isolated nature of the incident, the facility's exemplary record and prompt response, and the devastating consequences that the maltreatment determination will have in the small community where it operates. In essence, it is asking for a warning rather than a maltreatment determination because, in its view, even excellent facilities with excellent staff can have an unfortunate incident. Had they been aware when C.B. was enrolled that he had a habit of wandering, the staff could have taken more than the usual care, but in 21 years, the Respondent's training and procedures had worked well.

The owners are also upset that the Department gave notice of the maltreatment determination to the parents before a copy of the Order was sent to the Respondent, and because the Department allowed the newspaper to publish the maltreatment determination while the appeal was pending. In their view, they have been unfairly punished by the Department's errors.

Although the Respondent makes a strong case for leniency, there is no doubt that the incident meets the definition of maltreatment. The facility was supervising the child and its lapse placed the child in serious danger. Everyone involved felt responsible and was distraught about the harm that could have come to the child. No one individual was responsible; it was the lack of clear training and policies about the movement of children from the nap room to the lunch room in the proximity of an unlocked entrance to the parking lot that led to the incident.

The Child Abuse Reporting Act differentiates an "accidental" occurrence from neglect. "Accidental" means:

a sudden, not reasonably foreseeable, and unexpected occurrence or event which:

(1) is not likely to occur and could not have been prevented by exercise of due care; and

(2) if occurring while a child is receiving services from a facility, happens when the facility and the employee or person providing services in the facility are in full compliance with the laws and rules relevant to the occurrence or event.³²

In this case, it was foreseeable that a child would walk out of the facility through an unlocked entrance, and it occurred when the Department's rule addressing supervision was violated. At that time, the child was not in the sight

³² Minn. Stat. § 626.556, subd. 2(p).

or hearing of a staff member. If the facility staff had complied with the rule, the incident would not have occurred.

This is not to suggest that the staff members involved were derelict in their duties or were not genuinely concerned about children, nor does it minimize the evidence that the staff were distraught when the incident occurred. The staff's shared concern that each one might have contributed to what happened, and the Respondent's prompt retraining and installation of a door chime, support Respondent's claim that it is a good facility with excellent staff who were devastated by the incident, and that the incident was entirely inconsistent with both its philosophy and its record.

Nonetheless, the incident occurred and the Department has demonstrated by a preponderance of the evidence that it constituted maltreatment, that the facility was responsible, and that the \$1,000 fine should be imposed.

B.J.H.