

**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:** 202301716

**Date Issued:** May 3, 2023

**Name and Address of Facility Investigated:**

Nexus-Gerard Family Healing  
1111 28th Street NE  
Austin, MN 55912

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

**License Number and Program Type:**

831080-CRF (Children's Residential Facility)

**Investigator(s):**

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**Suspected Maltreatment Reported:**

It was reported that a staff person (SP) tackled an alleged victim (AV) to the ground and punched the AV in the face, causing a black eye.

**Date of Incident(s):** February 21, 2023

**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 March 1, 2023; from documentation at the facility; and through nine interviews conducted with facility supervisor (P1), facility staff persons (P2, P3, P4, P5 and the SP), a family member (FM) and the AV.

The facility provided residential treatment to youth ages six through eighteen who struggled with their emotions, behaviors, and mental health. The facility provided therapy and mental health resources. The facility's property was located off an interstate and off a frontage road. To the east of the facility was a golf course and between the golf course and the frontage road there was a chain link fence. On the day of the incident, the ground was covered with snow.

The AV's *Face Sheet* showed the AV was 17 years old at the time of the incident. The AV's *Residential Treatment Plan* stated the AV was artistic, loved animals and was social. The AV was diagnosed with attention deficit/hyperactivity disorder, major depressive disorder, disruptive mood dysregulation disorder, and an unspecified anxiety disorder. Staff persons helped the AV learn appropriate social skills and practice positive interactions and appropriate boundaries.

The facility's *Incident Report and Review*, written by the SP, stated that on February 21, 2023, at 2:45 p.m., staff persons were called to respond when the AV walked away from the facility and towards the road. The AV crossed the golf course, jumped a fence, and ran towards the interstate. As the SP approached the AV, the AV threatened to hurt the SP. The SP attempted to place the AV in a hold and both the SP and the AV fell to the ground. The AV punched the SP repeatedly and when additional staff arrived, the AV was placed in a hold. The AV had a black eye, swelling around the eye, and cuts on his/her face from thorns on the ground. The incident ended at 3 p.m.

The facility's *Program Abuse Prevention Plan* stated, "Regardless of the time of day, the youth care professional is an adult role model from whom the youth can learn and grow. As an adult role model, he/she establishes a trusting relationship with the youth. Through the trusting, therapeutic relationship, the youth feel a sense of security. When the youth feels secure with staff, growth can take place."

The AV stated that on February 21, 2023, s/he ran toward the "bridge near the highway" because s/he no longer wanted to be at the facility. Near the bridge, the AV was "tackled" by the SP and fell to the ground landing on his/her back on snow and branches. The SP then punched the AV twice in the left eye and then other staff persons intervened so the SP could not punch the AV again. The AV did not receive medical treatment but had a black eye that lasted a few days.

The FM stated that s/he was told of the incident by P1 and the AV. The FM stated that the AV had a history of leaving the facility and staff persons were to follow the AV and try to keep the AV from endangering him/herself.

P2 provided the following information:

- On February 21, 2023, at approximately 2:30 p.m., P2 responded to a call for help from the SP because the AV was leaving the facility. P2, P4, P5 and the SP got into the van and drove near the golf course. P2 and P4 got out of the van and were moving toward the AV on foot while P5 and the SP drove to the frontage road. P2, P3, and P4 followed the AV through the golf course and then the AV "hopped" over the fence and was moving toward the frontage road. P2, P3 and P4 also "hopped" over the fence and followed the AV at a distance.
- The AV was near the frontage road, saw the van and then moved back toward P2, P3 and P4. The SP got out of the van and moved toward the AV. As the SP got close to the AV, the SP "charged" and "tackled" the AV. When the SP "tackled" the AV, the AV landed on his/her back with the SP on top of the AV. Then the AV hit the SP in the face.
- The SP responded by hitting the AV in the face with a closed fist. Within ten seconds, P2 held the AV's right arm and P4 held the AV's left arm, in an attempt to place the AV in a "supine" hold. During this time, the SP hit the AV in the face approximately three or four times more. The SP "scouted" down to restrain the AV's legs, and as the SP was moving down the AV's body, the SP hit the AV in the stomach.
- Once the AV was restrained, the SP got off the AV's legs. P2 and P4 got the AV to a standing position and walked the AV to the van and P3, P4, P5, and the AV went back to the facility in the van. P2 and the SP walked back to the facility. While walking, the SP talked to P2 about "how to make this [the incident] look better on paper." P2 did not respond to the SP.
- The AV left the facility at the time because s/he was "frustrated." "Tackling" the AV did not need to happen because the AV was not trying to hurt him/herself at the time.

P3 provided the following information:

- On the day of the incident, when the AV left the facility, P3 followed behind the AV but gave space to allow the AV time to "cool down." The AV then ran down the "driveway" and then ran into the golf course and running toward the interstate. P3 was trying to keep the AV away from the ramp onto the interstate and once P3 saw the van, P3 moved more toward the AV.
- While P3 was behind the AV, P3 saw a door to the van open and the SP jumped out and started running toward the AV. P3 then started running toward the AV and the SP and saw the SP dive toward the AV and then get up on his/her knees. P3 saw the SP bring up his/her fist and then down two times. P3 began to run faster and was not able to continue to watch the SP. When P3 arrived at the AV and the SP, the AV's glasses were broken, and the AV had scrapes on his/her face and his/her left eye was swollen.
- The AV stated that s/he wanted to call the police and P3 asked the AV why. The AV replied because the SP had hit him. The SP denied hitting the AV.
- From training P3 received, P3 did not believe the SP should have tackled the AV. P3 believe the AV could have been placed in a hold or guided to where the staff persons wanted him/her to go.

P4 provided the following information:

- P4 followed the AV on foot through the golf course and over a fence toward the frontage road. P4 was attempting to get in front of the AV and guide him/her to the van. At this time, the AV turned and was running when the SP ran and tackled the AV. The AV hit the SP one or two times and then the SP hit the AV in the face three or four times with a closed hand.
- P4 grabbed the SP's right arm to stop the SP from continuing to hit the AV and then P2 and P4 put the AV in a restraint hold. Once the SP was moved away from the AV, P2 and P4 were able to get the AV calmed and into the facility van.
- The SP told P4 that the AV ran at him/her with his/her fists balled and hit the SP. The SP also told P4 that s/he attempted to block the AV's hits and if his/her hands were bloodied it was because s/he fell on the ice.
- P4 did not believe the SP should have tackled the AV. P4 stated there were enough staff persons present to "herd" the AV away from the road and to the van and the SP's actions were not consistent with the techniques used at the facility.

P5 provided the following information:

- On the day of the incident, P5 heard the call for assistance and learned the AV was all the way down the driveway so P5 grabbed keys for the van. The SP and P2 were outside and got into the van while P5 drove. When the van was by the golf course, P2 got out and followed the AV on foot along with P3 and P4.
- The AV was running across the golf course, jumped a fence and was headed toward the frontage road. As the AV was moving up a slight incline toward the frontage road, the SP asked P5 to stop the van and P5 did so. The SP got out of the van, ran down the ditch, and tackled the AV to the ground.
- P5 could see P2, P3, and P4 moving toward the AV. P5 drove further down the road, turned around and came back and saw the other staff persons putting the AV in a hold. P5 exited the van to supervise the hold. P2 and P4 had the AV in a hold and the SP was holding the AV's legs. The AV yelled that the SP had assaulted him/her and asked for the police to be called.
- The AV was escorted to the van and driven back to the facility. When back at the facility, P5 checked on the AV and the AV said s/he had been punched in the face multiple times. P5 said s/he did not see the SP punch the AV, but P5 saw redness and swelling around the AV's left eye.
- P5 did not believe the tackle was necessary because in the past, the AV had stayed on the side of the road and had not entered or crossed the road and there were four staff persons around the AV.

P6 was interviewed by this investigator but was not involved in the incident and did not have information relevant to the allegations.

The SP provided the following information:

- On February 21, 2023, the SP heard a call that the AV had left the facility so the SP, P2 and P5 got into the van and started to drive toward the golf course. The van stopped on the frontage road and the SP got out.
- The AV then ran towards the SP with his/her hands in fists, so the SP ran towards the AV. As the AV was running, the SP attempted to put the AV in a hold, "almost like a tackle." In doing so, both landed on the ground with the AV on the bottom, face down, and the SP on top. The AV "flipped over like lightning" and hit the SP in the face, causing a cut on the SP's lip and causing a loose tooth. The SP stated s/he was "blocking" the AV's "punches."
- The SP stated that s/he stopped the AV from running toward the road because s/he did not want the AV to be hit by a car or truck.
- The SP denied hitting the AV. The SP said was blocking hits from the AV, trying to change the direction of the AV's hands, and "shoving" the AV's hands to the ground and that if s/he had any contact with the AV's face, it was unintentional. The AV's black eye could have been caused when the AV fell face first on the ground.

P1 provided the following information:

- On February 21, 2023, the AV had been "dysregulated" most of the afternoon and at approximately 2:40 p.m., the AV ran out of the facility, down the road, through the golf course, over the fence, and toward the frontage road.
- When the AV ran out of the facility, a call was made asking for assistance from other staff persons. Some staff persons followed the AV on foot while some, including the SP, followed in a facility van. P1 remained at the facility.
- After the incident, P1 saw that the AV's left eye was swollen and developed into a black eye.
- P1 spoke to and/or had P2, P3, P4, P5, and the SP write a statement and each provided information that was consistent with the information each provided during their interviews. P1 said that staff persons should have waited until all staff were near the AV and then guide him/her back toward the facility. Staff persons could have placed the AV in a hold if s/he became aggressive.

Facility documentation showed that all staff persons interviewed for this investigation received training on the Reporting of Maltreatment of Minors Act. The SP was trained on the facility's *Program Abuse Prevention Plan* on December 27, 2022.

**Conclusion:**

A. Maltreatment:

On February 21, 2023, the AV left the facility and was followed by five staff persons on foot and via the van. The AV was near a frontage road to an interstate as staff persons were nearing him/her. The AV, P2, P3, P4, and P5 provided consistent information that the SP ran toward the AV and tackled the AV to the ground. The AV, P2, and P4 stated that then the AV hit the SP and the SP punched the AV more than once in the face and in the stomach. P3 stated that s/he saw the SP's arm move up and down as s/he ran to the SP and the AV and when s/he arrived the AV's glasses were broken, and the AV had scrapes on his/her face and his/her left eye was swollen. P5 stated s/he did not see the incident but P5 was in the van turning it around at the time. Immediately after, the AV had scratches on his/her face, his/her glasses were broken, and his/her left eye was swollen and then developed into a black eye.

The SP denied hitting the AV and said that s/he might have unintentionally hit the AV in the face as s/he was attempting to block the AV from hitting him/her. However, given that the SP had reason to minimize his/her interactions for fear of repercussion; that the AV said the SP hit him/her; that P2, P3, P4, and P5 each saw the SP tackle the AV; that P2 and P4 each stated they saw the SP hit the AV in the face more than once; that P3 observed the SP's arm move up and down and then the AV had an injury; and that immediately after the incident, the AV had a swollen and bruised eye and the AV's glasses were broken, there was a preponderance of evidence that the SP's actions were not accidental and caused injury to the AV.

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.)

In addition, given that P2, P3, P4, and P5 each stated that the AV was not a danger to him/herself or others at the time of the incident, the SP's actions of physically intervening with the AV were inconsistent with the standards of a professional caregiver in a facility licensed by the Department of Human Services and there was a preponderance of the evidence that there was a failure to supply the AV with necessary care and a failure to protect the AV from conditions or actions that seriously endangered his/her physical or mental health or safety.

Therefore, 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 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.

The SP was trained on the Reporting of Maltreatment of Minor's Act and the *Program Abuse Prevention Plan*.

The SP was responsible for maltreatment of the AV.

#### 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 abuse for which the SP was responsible did not meet statutory criteria to be determined as recurring because this was a single incident that met two definitions of maltreatment, but was serious because the AV sustained a black eye.

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 Human Services 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 and followed. The SP no longer worked at the facility.

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

The SP was notified that s/he was responsible for serious maltreatment and that any future background studies for facilities, programs, organizations, and/or agencies that are required to have individuals complete a background study by the Department of Human Services as listed in Minnesota Statutes, section 245C.03, will result in his/her disqualification. The determination that the SP was responsible for maltreatment 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 Human Services.