

**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:** 202407637

**Date Issued:** September 18, 2025

**Name and Address of Facility Investigated:**

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

**Disposition:** Maltreatment determined as to physical abuse and neglect 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) squeezed an alleged victim (AV) around his/her neck. It was also reported that the SP dragged the AV out of bed by his/her ankles and the AV sustained a bruise to his/her leg.

**Date of Incident(s):** September 2, 2024

**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 September 13, 2024; from documentation at the facility; and through eight interviews conducted with a facility supervisory staff person (P1), four staff persons (P2, P3, P4, and the SP), the AV, the AV's social worker (SW), and the AV's family member (FM).

The AV was 13 years old and diagnosed with attention-deficit/hyperactivity disorder, persistent depressive disorder, conduct disorder, and disinhibited social engagement disorder. The AV liked to play volleyball, basketball, and spend time with his/her peers. The AV was working on "developing a skillset to reduce episodes of physical and emotional dysregulation and aggression." The AV's plans stated that if the AV "became a safety risk to [him/herself] and/or others, a physical hold procedure may need to be enacted."

The facility was a residential mental health treatment facility that assisted youth ages six to eighteen years old. The AV resided in a dorm that consisted of a programming room and six bedrooms. The AV's bedroom had two sets of bunk beds that accommodated up to four residents. The AV had a top bunk. Outside of the AV's bedroom was a small hallway that led to other bedrooms and programming area. The facility had cameras in the main areas but none inside the bedrooms. However, part of the AV's bedroom, including part of the AV's bed, was visible from one of the camera views.

The *Therapeutic and Restrictive Procedures* said that staff persons were to "ensure that the safety, rights, and dignity of the youth that we serve are maintained." Staff persons were required to complete a course and demonstrate competency on approved holds. The facility used "Handle with Care" which stressed the use of verbal de-escalation techniques and then physical holds only as a last resort when "less invasive interventions have been attempted and proven to be unsuccessful." Physical holds were only to be implemented if "the safety of the youth and others if imminent danger is present by means of physical aggression" or for "the prevention of self-harm/self-destructive behaviors that put the youth or others in imminent danger." There were multiple variations of holds but all utilized "Primary Restraint Technique" (PRT). PRT was a "skeletal lock position in which the staff member's chest is in close, elbows under elbows, fingertips and, more importantly, wrists are pointed straight up."

Consistent information was provided that on September 2, 2024, P2, P3, and the SP worked in the AV's dorm.

The AV and the *Workplace Investigation* provided the following information:

- On September 2, 2024, in the morning, the AV was refusing to get out of bed which was the top bunk. The dorm was in a "slow down" because the youth in the dorm were not "behaving." This meant that there were no "fun" activities, and the AV did not want to get out of bed.
- At about 8:10 a.m., the SP and P2 went into the AV's room. The SP then grabbed the AV's left leg and P2 grabbed the AV's arms and pulled the AV to the floor. When the SP and P2 pulled the AV out of his/her bed, the AV's leg hit the ladder of the bunk bed. The AV then accidentally hit the SP in the stomach and the SP put his/her arms around the AV's neck and the AV fell to the floor. The AV could not breathe and

tapped the SP on the arm. The SP released his/her arms from the AV's neck. The AV counted and the SP had his/her arms around the AV's neck for 30 seconds. The AV went into the hallway just outside of his/her bedroom to "get away" from the situation. P2 followed the AV into the hallway and the AV pushed P2. P2 then put the AV into a hold.

- The AV showed his/her left leg to this investigator and said that there was a bruise (Note: This investigator did not see any injuries). There were no injuries to his/her neck from the incident.
- The AV said that the SP and P2 should have tried talking with him/her instead of dragging him/her out of bed.

P2 and the *Workplace Investigation* provided the following information:

- On September 2, 2024, P2 worked in the AV's dorm starting at 7 a.m. After breakfast, the AV was in his/her room and refused to get out of bed. P3 was trying to encourage the AV to get out of bed for an activity but the AV continued to refuse to get out of bed. P3 left the AV's room to supervise the other youth in the programming area.
- In between 8:15 and 8:45 a.m., P2 was supervising the other youth in the programming area. The SP, who was returning to the dorm after using the restroom, told P2 that s/he was going to "drag" the AV out of bed if the AV was still refusing to get out of bed. The SP started to walk toward the AV's room and P2 followed because s/he wanted to see if the SP would be successful in getting the AV out of bed.
- When the SP and P2 arrived in the AV's room, the SP verbally encouraged the AV to get out of bed. The AV refused and the SP then grabbed one of the AV's ankles. P2 was not sure if the SP grabbed the AV's right or left ankle. The AV said, "Ow," when the SP grabbed his/her ankle. When the SP started to pull on one of the AV's ankles to get the AV out of bed, P2 held the AV's head and arm with an "open palm" and leaned the AV "forward" because s/he was worried the AV would hit his/her head and/or fall to the floor. When the AV was "halfway down" off the bunk bed, the SP let go of the AV's ankle and the AV landed with his/her feet on the floor. The AV then attempted to punch the SP in the stomach so P2 attempted a hold. During this, the SP "tackled" the AV and used his/her left arm and wrapped it around the AV's neck in a "chokehold." The SP and the AV both ended up on their knees. P2's right arm was in between the SP and the AV from P2's attempted hold on the AV. The AV said that s/he "couldn't breathe," and the SP released his/her arm from around the AV's neck.
- The AV went into the short hallway outside his/her room and started to scream and yell. P3 came to the hallway and was pushed onto the floor by the AV. The AV then started to hit P2 so P2 put the AV into a hold until s/he calmed. After P2 ended the hold on the AV, P2 went to supervise the other youth in the dorm while the AV stayed in the hallway outside his/her room for "awhile." The AV was able to "turn [his/her] day around" after the incident and followed "expectations."
- P2 did not see any injuries or bruises on the AV. P2 was "pretty sure" that the AV mentioned a bruise on his/her leg but P2 did not see the bruise.
- In general, the SP would "brush off" comments from others regarding the care of the youth. P2 felt that

the SP would not have listened to him/her if s/he would have objected to pulling the AV out of bed. P2 said that holding someone around their neck was not an approved hold and that the SP should have left the AV in bed because the AV was not in any danger of hurting him/herself or others.

P1 and the *Workplace Investigation* provided the following information:

- On September 2, 2024, between 5:30 and 6 p.m., a supervisory staff person (P5) told P1 that P2 told him/her that between 8 and 9 a.m. that morning, the SP wrapped his/her arms around the AV's neck from behind. P2 told P5 that s/he was "afraid" to say something earlier in the day while the SP was still on shift. P5 told P1 that the AV was "doing okay" and there were no signs of injury to the AV's neck. However, P2 saw a bruise on the AV's left leg. The AV was not seen by medical personnel as the incident happened in the morning and the AV was "doing okay."
- P1 reviewed camera footage from September 2, 2024, that showed the hallway and the doorway of the AV's dorm room. The SP and P2 enter the AV's dorm room at 8:22 a.m. and the SP, P2, and the AV exit the room around 40 seconds later.
- P1 said that if a youth was refusing programming/activity, the staff person should provide encouragement for the youth to "get back on path" but should "wait them out" and make sure the youth understood the consequences of doing or not doing a planned activity.
- On September 3, 2025, the AV was brought by P1 to meet with P4 to discuss the situation. The AV did not give "a lot of info" so P1 met with the AV. P1 encouraged the AV to discuss the incident with P4. P1 thought that the AV's history of not always providing accurate information caused the AV to be hesitant about discussing the incident.
- P1 previously brought up concerns to the SP regarding his/her behavior at the facility. This included that the SP had been more "snippy" when interacting with the youths and had a "negative attitude" when coming into work.
- P1 was told by another supervisory staff person who spoke with the SP, that the SP denied choking the AV but admitted to "bear hugging" the AV, which P1 said would still not be "considered a handle with care hold."

P3 and the *Workplace Investigation* provided the following information:

- On September 2, 2024, before 8 a.m., the AV completed personal cares and then returned to his/her bed and was refusing to get out of bed. Around 8:15 a.m., P3 tried encouraging the AV to get out of bed but the AV refused. The SP then went into the AV's room and told the AV that if the AV did not get out of bed that s/he was going to "pull" or "drag" the AV out of bed.
- The SP went to use the restroom and P3 left the AV's room to supervise the other youth in the programming area. Around 8:30 a.m., when the SP returned, P2 followed the SP into the AV's room. P3 heard the AV screaming and crying "get off me" and "get your hands off of my neck." The AV stood in the doorway of his/her dorm and yelled that the SP had "no right to choke [him/her]." The AV then "went

after" the SP so P2 tried to put the AV in a hold in the hallway just outside the AV's dorm. P3 tried to assist with the hold but while doing so, P2 and the AV went to the floor. P2 and the AV were rolling on the floor and P3 got bumped into and fell to the ground when s/he tried to assist with the hold. The AV got his/her hair into his/her mouth during the hold and asked for his/her hair to be removed from his/her mouth. P3 went to assist the AV, and the SP yelled that P3 should not help the AV as getting hair in the AV's mouth was a "natural consequence" for his/her actions. The SP asked the AV why s/he hit him/her and told the AV that s/he would not have "put my hands on you if you didn't hit me."

- P2 told P3 that the SP told him/her that they were going to "pull" the AV out of bed. P2 also told P3 when the SP pulled the AV out of bed, P2 caught the AV and prevented them from falling to the floor.
- After the incident, P3 noticed a few scratches on the AV's neck. P3 did not see the SP put his/her hands on the AV's neck but did hear the AV yell, "Why did you put your hands on my neck?"
- P3 said the AV should have been left in bed if s/he was refusing to get up. If the AV was choosing to be "off path," staff persons should not force the AV to do anything.

P4 provided the following information:

- On an unknown date, P4 received an email on a Sunday that asked him/her to discuss a situation with the AV when s/he arrived to the facility the following morning.
- On September 3, 2025, the AV recalled the incident to P4. The AV was on the top bunk and was refusing to get out of bed because s/he "didn't feel like it." The SP grabbed his/her ankles and P2 grabbed his/her arms and pulled him/her down off the bed. The AV landed on the floor and "swung" his/her arm to push past the SP and accidentally hit the SP in the stomach. The SP got behind the AV and put his/her arms around the AV's neck. The AV said that s/he could not breathe and could not talk so s/he started to "tap" the SP on the arm. The SP released the hold around the AV's neck and put the AV's arms into a hold for around 30 seconds.
- The AV showed P4 a bruise on the outside of his/her left leg. The bruise was about three to five inches long in an oval shape and was "brownish yellow" in color. P4 did not know if the AV had this bruise prior to the incident. P4 did not take a photo of the bruise and was not aware of anyone else taking a photo of the bruise. P4 did not see any injuries on the AV's neck and the AV said, "No," when P4 asked if s/he had any injuries to his/her neck.
- P4 said that staff persons were to provide "encouragement" to the youth but if they choose to be "off path" to "pause the routine." A youth should never be dragged out of bed if they were refusing to get out of bed. A staff person should never put their hands on a youth's neck during a hold.

The FM said that the AV had a history of providing false information while living with the FM and had recently accused staff persons of not assisting the AV when the AV was "assaulted" by another youth at the facility. Camera footage of the "assault" incident was not consistent with the information the AV provided.

The SW would visit the AV in the facility once per month and would talk on the phone a "couple time" a month.

The SW said that the AV had a history of not always providing accurate information and would use “manipulation” to get his/her way.

The SP provided the following information:

- On September 2, 2024, the SP was scheduled to start at 6:50 a.m. When the SP arrived for his/her shift, s/he was informed by P5 that the dorm was to be in a “slow down.” This included that the previous night, there were multiple incident reports including one with the AV. Chairs in the dorm were turned to face the wall, so the youths “knew” that the dorm was in a “slow down.” The AV was “upset” by this and questioned why s/he needed to be a part of the “slow down.” The SP explained to the AV that his/her actions from the previous night were a part of the reasoning. The AV “got mad” and refused to get out of bed. P2 and P3 tried verbal encouragement with the AV but were unsuccessful.
- At 8:23 a.m., the SP and P2 entered the AV’s dorm room. The SP tried verbal encouragement to get the AV out of bed but was also unsuccessful. The AV was in the top bunk and the SP initially stepped on the ladder to pull the AV out of bed but decided to stay on the floor. The SP went to grab both of the AV’s legs but only grabbed one of his/her ankles as the AV started to kick at the SP. P2 then grabbed the AV’s “upper body” and the SP and P2 pulled the AV out of bed and the AV “tumbled” onto the floor. The AV immediately got up and attempted to punch the SP in the stomach. The SP moved to the side and then “hugged” the AV. The SP and the AV fell to the floor and then both got up off the floor. The AV separated from the SP’s hold and went into the hallway, slamming the door on the way out. P2 put the AV into a hold and the SP called P3 for help. When P3 got into the hallway where P2 was holding the AV, the SP “stepped back” and then filled out an incident report for the AV being put into a hold.
- The SP and P2 “debriefed” after the incident. The SP and P2 agreed that the AV should not have been pulled out of bed. P2 mentioned that while the SP and the AV were on the ground, the AV said that s/he “couldn’t breathe.” The SP thought the AV’s “ginormous” sweatshirt could have gotten into a “weird” position while trying to hold the AV and maybe that was why the AV said that s/he could not breathe. The SP’s hands were “nowhere near” the AV’s neck. The SP said that s/he did not “intentionally” hurt the AV and in his/her witness statement for the *Workplace Investigation*, wrote that s/he “did not choke [the AV].”
- Following the incident, the AV said his/her arms “hurt.” No other injuries to the AV were noted. The SP was not aware of a bruise on the AV’s leg. However, the AV was put in multiple holds “every day” and any one of those could have caused the bruise on the AV’s leg.
- A “few hours” after the AV was pulled out of bed by the SP and P2, the SP asked the AV if s/he wanted to go out for lunch and the AV said, “Yeah.” The SP and the AV got lunch and came back to the facility. The SP and the AV “chilled” for 10 to 15 minutes “off unit.” The AV “complained” about how s/he did not get along with the other youths but otherwise “seemed fine” and did not bring up the “hold from the morning.”
- The SP said the AV could have stayed in bed and the SP did not think of that “until after.” If the SP allowed

the AV to remain in bed, the AV would have eventually left his/her bed, stopped refusing, or gone to the bathroom.

Facility records showed that P1-P4 and the SP were all trained on the AV's plans, the Reporting of Maltreatment of Minors, and the *Therapeutic and Restrictive Procedures* policy.

### Conclusion:

#### A. Maltreatment:

Information was consistent that on the morning of September 2, 2024, the AV was refusing to get out of bed and verbal attempts by P3 to get the AV out of bed were unsuccessful. At 8:22 a.m., the SP went into the AV's room and P2 followed. After attempting to verbally redirect the AV to get out of bed and the AV's refusal, the SP grabbed one of the AV's ankles and started to pull the AV from the top bunk. P2 stated that when the SP started to pull the AV out of bed, P2 held the AV by the head and arm to help protect the AV from injury and falling to the floor. While being pulled out of bed, the AV's leg hit the ladder of the bunk bed. When the AV got to the floor, the AV's arm hit the SP in the stomach. P2 attempted a hold on the AV but the SP put the AV in a hold with either one or both of his/her arms around the AV's neck. This hold pinned P2's arm in between the AV and the SP. The AV said that s/he "couldn't breathe" and the SP released the hold.

Although the SP denied putting his/her arm around the AV's neck, given that P2 and the AV each stated the SP put his/her arm around the AV's neck and P3 heard the AV say to "get your hands off my neck," it was determined that the SP had his/her arm around the AV's neck. In addition, information was consistent that the SP initiated pulling the AV out of the top bunk which caused the AV to hit his/her leg on the ladder and fall to the floor when the SP should have used verbal redirection and not done so. Given this, there was a preponderance of the evidence that the SP's actions were not accidental and represented threatened injury and that the SP failed to protect the AV and supply the AV with care required for the AV's physical or mental health.

It was determined that physical abuse and neglect 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; 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.

While P2 did hold the AV's head and arm when s/he was pulled out of bed, P2 actions were a response to when s/he saw the SP start to pull the AV out of bed and held the AV's head and arm to protect the AV from falling to the floor, therefore P2's responsibility is mitigated.

The SP was trained on the AV's plans, the Reporting of Maltreatment of Minors, and the *Therapeutic and Restrictive Procedures* policy. 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 physical abuse and neglect for which the SP was responsible did not meet statutory criteria to be determined recurring because it was a single incident or serious because it was not determined how or when the AV sustained a bruise on his/her leg.

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 their policies and procedure were adequate but not followed, including because staff persons did not “engage” in the appropriate type of restraint based on their training. The facility provided additional training around the “necessity to engage in appropriate restraint techniques” according to the “trained models.” The SP no longer worked at the facility.

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

The SP was not disqualified from providing direct care services as a result of the maltreatment determination in this report. However, the SP was 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 the SP. 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.