

**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:** 202508271

**Date Issued:** November 4, 2025

**Name and Address of Facility Investigated:**

**Disposition:** Maltreatment determined.

Nexus East Bethel Family Healing  
900 189th Ave NE  
East Bethel, MN 55011

**License Number and Program Type:**

1119782-PRTF (Psychiatric Residential Treatment Facility)

**Investigator(s):**

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**Suspected Maltreatment Reported:**

It was reported that a staff person (SP) pushed and hit an alleged victim (AV), grabbed the AV's hair and threw him/her to the floor by his/her hair, pinned the AV to the floor, and sat on the AV and held the AV to the floor with his/her legs.

**Date of Incident(s):** September 4, 2025

**Nature of Alleged Maltreatment Pursuant to Minnesota Statutes, section 260E.03, subdivision 18, paragraph (a), and subdivision 23, paragraph (a):**

"Physical abuse" means any physical injury, mental injury, or threatened injury, inflicted by a person responsible for the child's care on a child other than by accidental means. "Threatened injury" means a statement, overt act, condition, or status that represents a substantial risk of physical or sexual abuse or mental injury.

**Summary of Findings:**

Pertinent information was obtained during a site visit conducted on September 18, 2025; from documentation at the facility and law enforcement records; and through interviews conducted with facility staff persons (P1, P2, P3, P4, and the SP), the AV, and the AV's guardian (G). This investigator spoke with the SP by telephone, but the SP declined to complete an interview.

The facility provided services to individuals aged 12 to 19 with significant mental and behavioral health issues in a program to support families throughout the treatment process. The facility had a video recording system that recorded common areas of the facility, but the video recordings did not have sound. On campus, individuals received education services, therapies personalized to their needs, and recreational opportunities.

Facility documentation showed that the AV was diagnosed with attention deficit hyperactivity disorder and oppositional defiant disorder. The AV might become angry quickly and wanted to learn to better regulate his/her emotions. If the AV was upset, s/he might hit, kick, or bite staff persons, or pull their hair. When staff persons observed the AV becoming dysregulated, they were to encourage the AV to use coping skills to decrease his/her distress. Indications that the AV was upset included having an angry facial expression, staring, looking around the room, and/or pacing. Staying busy was important to the AV and s/he wanted staff persons to distract him/her when s/he was mad or sad. Staff persons could use permitted manual restraints with the AV if s/he posed an imminent risk of harm to him/herself or others. The AV liked to play and enjoyed one on one time with staff persons.

Interviews with this investigator, facility documentation, records from a law enforcement agency, and the facility's *Internal Review*, provided the following:

- The AV said that on the date of the incident, s/he hit the SP and attacked him/her. The SP then threw the AV to the floor, told him/her that s/he was an "f-ing bitch," pulled the AV's hair, and scratched him/her. During the incident, the AV was lying on his/her back on the floor with the SP leaning over him/her. At some point during the incident, the SP's knee was on the AV's stomach/chest. The AV was really scared and thought that the incident lasted between two to five minutes. The incident ended when P1 told the SP to "stop it." The AV had small red marks on the inside of his/her left arm when this investigator interviewed him/her.
- P1, a milieu lead staff person, stated that the incident occurred quickly and it was difficult to remember each detail. On the date of the incident, the AV was dysregulated and there were multiple crises at the facility. The AV was engaging in property destruction, so P1 redirected the AV, and the AV hit P1, who blocked the AV's hits. The AV then began hitting the SP and the SP said, "Get [the AV] the fuck off me," and told the AV to, "Get the fuck away from me." The AV continued physically aggressing toward the SP, and initially the SP blocked the AV's hits, but then stepped toward the AV and pushed him/her. The AV did not fall, but s/he grabbed the SP's hair and then fell backward and pulled the SP toward him/her. The SP fell forward and was leaning over the AV, with his/her legs possibly on the AV's legs. The SP grabbed the AV's hair and P1 attempted to get between the AV and SP to pry their hands from each other's hair. The AV and SP each told the other to, "Stop hitting me," and P1 instructed them to release each other's hair. The AV released the SP's hair, and P1 told the SP to go to the facility's office. The SP walked toward the office, but told the AV, "You little bitch, go to fucking hell." After that, the AV was in total dysregulation, according to P1. P1 called administrative staff persons for assistance on his/her walkie

talkie, and they came to the unit to assist P1. After the incident, the VA had scratches on his/her arms from the SP's fingernails and minor bruising that might have resulted from the incident. P1 said that if a youth attempted to hit staff persons, staff persons were to block the hits but could implement permitted restraints when safe to do so.

- P2 said that the incident began with the AV pushing the SP, but the SP "stood [his/her] ground," and pushed the AV back. The AV and SP pulled each other's hair and fell, then P1 intervened to separate them. P2 was especially concerned when it looked like the SP was sitting on the AV's stomach while the AV was lying on his/her back on the floor. P2 did not observe any injuries to the AV, but there was a lot going on and s/he was unsure of the details of the incident.
- P3 and P4, who were supervisory staff persons, provided consistent information that they had each supervised the SP during the time the SP worked at the facility. P3 viewed the video recording of the incident and provided an account of the incident that was largely consistent with the account given by P1. Pushing a youth and/or pulling his/her hair were not permitted actions at the facility, and staff persons were to switch out with other staff persons or take a break if they felt stressed.

The video recording from the facility showed that the descriptions provided by P1 and the AV of the physical contact between the SP and AV during the incident, were accurate. It was unclear whether the SP sat on the AV's chest/stomach or placed his/her knee or legs on the AV, but there was physical contact between the AV and the SP, including hitting, pushing, and hair pulling. Immediately after the incident, the AV hit the back of his/her head on a facility wall several times, but P1 quickly intervened and moved the AV away from the wall.

Records from the law enforcement agency showed that on September 4, 2025, a law enforcement officer (LEO), who was at the facility for a separate matter, was notified of the incident with the AV and the SP. The LEO met with facility administrators, viewed the video recording of the incident, and spoke with the AV. The LEO documented that the video recording showed that the AV "went after" the SP and hit him/her multiple times. The SP pushed the AV away with both hands and the AV and the SP grabbed each other's hair, then fell to the floor, and began "struggling" with each other. P1 returned and separated the AV and the SP, then the SP stood and left the area. The LEO asked the AV about the incident and the AV told the LEO that s/he was aggressive, hit P1 first and then hit the SP again and pulled the SP's hair. The AV told the LEO that the SP scratched the AV and told him/her, "Go to hell bitch." The AV felt "really scared," had a panic attack, and described the incident as painful and traumatizing. The AV had scratches on his/her upper forearms. The LEO wrote that the incident might have been against the facility's policies and procedures and/or unprofessional, but it appeared to be self-defense and not criminal. The agency took no further action.

The facility's personnel and training records showed that staff persons who provided information for this report were trained on the Maltreatment of Minors Act and the facility's policies and procedures prior to the incident.

### **Conclusion:**

#### **A. Maltreatment:**

Information was consistent that on September 4, 2025, there was physical contact between the AV and SP during which the AV hit the SP, the SP pushed the AV, and the AV and SP pulled each other's hair. During the incident,

the AV and SP fell to the floor with the AV lying on his/her back, and the SP leaning over him/her. The incident ended when the AV released the SP's hair, and the SP went to the facility office. The SP declined to complete an interview with this investigator, but information from P1 and the AV showed that during the incident, the SP told the AV that s/he was an "f-ing bitch, told the AV, "Get the fuck away from me," and said, "You little bitch, go to fucking hell." In addition, the SP asked others to, "Get [the AV] the fuck off me." After the incident, the AV had scratches on his/her arms and minor bruising that might have resulted from the incident. The AV said that s/he was really scared, described the incident as painful and traumatizing, and had a panic attack.

The law enforcement agency did not take criminal action based on the incident, and it was unknown whether the AV's scratches/bruises were sustained during the incident. However, given that the AV was scared, felt traumatized and hit his/her head against the wall several times after the incident, and that the SP's actions of pushing the AV and using profanity directed to the AV were non-accidental non-therapeutic overt acts, there was a preponderance of the evidence that the SP engaged in behavior which represented a substantial risk of physical or mental 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).

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 responsible for the care of the AV at the time of the incident. A video recording of the incident showed that the SP pushed the AV and pulled his/her hair, and information from P1 and the AV showed that the SP used profanity toward the AV during and after the incident. The SP was responsible for the 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 it was a single incident and did not meet statutory criteria to be determined as serious because it was unclear whether the AV sustained scratches or bruises as a result of the SP's actions or by accidental means.

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* which determined that their policies and procedures were adequate but

were not followed. At the time this report was written, the SP was no longer employed 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.