Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL254942902M
Compliance #: HL254945229C

Date Concluded: November 18, 2025

Name, Address, and County of Licensee Investigated:
State Operated Psychiatric Nursing Facility- St. Peter
100 Freeman Drive
St. Peter, Minnesota 56082
Nicollet County

Facility Type: Nursing Home

Evaluator's Name: Nicole Myslicki, RN
Special Investigator

Finding: Substantiated, individual responsibility

Nature of Investigation:
The Minnesota Department of Health investigated an allegation of maltreatment, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557, and to evaluate compliance with applicable licensing standards for the provider type.

Initial Investigation Allegation(s):
The facility abused the resident when staff administered a medication, which may not have been warranted, after the resident displayed aggression and agitation.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was substantiated. The alleged perpetrator (AP) was responsible for the maltreatment. The AP inflated the description of the resident's behavior during a night shift. The AP requested and obtained an order for injectable psychotropic medications without the resident's behaviors demonstrating the need for them, resulting in a chemical restraint.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of the resident record, facility internal investigation, facility incident reports, personnel files, staff schedules, and related facility policy and procedures. Also, the investigator observed the layout of the unit.

The resident resided in a nursing home. The resident's diagnoses included schizoaffective disorder. The resident's care plan included assistance with medication administration. The care plan also indicated staff would administer as needed (PRN) medications as needed, related to anxiety and a delusional disorder. The resident's assessment indicated the resident displayed symptoms of delusions, irritability, and verbal aggression. The resident's individual abuse prevention plan (IAPP) indicated the resident had been verbally aggressive toward staff, unprovoked.

An incident report indicated the resident had been verbally aggressive and agitated throughout an overnight shift. The report indicated the resident began "storming down the south wing" where other residents slept. An incident command system (ICS) was initiated for additional support, and the resident eventually allowed an injection of as needed (PRN) psychotropic medications to be given without [manual] restraint.

An internal investigation indicated, after video footage review and initial interviews, it did not appear standard nursing practice had been followed, including completing a nursing assessment on the resident, and interventions were not offered prior to given the injection.

An internal review indicated several unlicensed personnel (ULP) reported concerns about the accuracy of what the AP reported regarding the events of the resident's behavior on the overnight shift. They reported throughout the shift, the AP did not approach the resident and did not appear to be checking to see if interventions should have been put in place. Additionally, the resident's behavior did not seem to rise to the level of needing injectable medications, and they did not understand why the ICS had been called. The internal review included several interviews with staff. During an interview, ULP-1 stated the AP heard the resident yell at her around 1:30 a.m., but did not say anything. Later, the resident began to escalate and yell out, but the AP did not try talking with him or offer his PRN medication. The AP ignored it like she did not care and did not communicate her plan to call an ICS. The AP said the resident had been attacking staff, but he video footage and staff reports indicated he did not. During an interview, ULP-2 stated although the resident appeared more verbally agitated than normal, the resident always yelled if staff asked him anything. ULP-2 stated she had not been worried about her safety and there were no signs the resident was going to assault her. Normally, when an ICS got called, everyone would take a radio and go to the scene. This time, however, ULP-2 did not even know they were having an ICS. The internal review also included an interview with the psychiatrist on-call at the time of the incident. The psychiatrist reported he received a call around 6:00 a.m. that the resident was physically aggressive, yelling, and not willing to take oral medication. Based on the imminent threat to others in the report he received, he gave a one-time order for two IM (intramuscular) injection medications. The psychiatrist had not heard anything the whole night regarding the resident prior or after that one conversation. The internal review also included an interview with the AP. During this interview, the AP stated the resident had been up quite a bit of the night. At one point, the resident jumped up from the recliner, yelled derogatory terms, and threatened the aides at the

desk, saying things like he wanted to kill staff. Later in the interview, the AP clarified the resident did not actually jump up but got up more quickly than he did at other times. The AP stated staff felt threatened. The AP acknowledged the resident had an oral PRN medication ordered as an intervention for his behavior but stated she would not approach him and offer the medication because he already told staff to “go to hell.”

The investigation included review of video footage from the shift on which the incident occurred. During the video footage, the resident mostly sat in a recliner chair. The resident did get up and walk around the facility, including walking down the hallway and apparently yelling out, although it did not include audio. The footage showed the resident did not attack or lunge at staff or other residents. The footage also showed the resident appeared calm most of the shift, including in the morning hours during the time the ICS had been called, while the secondary team responded, and before, during, and after receiving the injection.

The resident’s medication record included an order for lorazepam 2 milligrams (mg) per milliliter (mL) intramuscularly (IM) 1 mg one time for agitation and psychosis. The record indicated the resident received the IM injection of lorazepam at 6:39 a.m., and the results were effective. The record also included an order for haloperidol 5 mg per 1 mL IM, 5 mg one time for agitation and psychosis. The record indicated the resident received the IM injection at 6:40 a.m., and the results were effective.

The resident’s record included several progress notes from around the time of the incident.

A progress note written by the AP, at 4:00 a.m., indicated the resident walked up to another resident and tried to take his food. Staff had to yell out the resident’s name several times to get him back off, as the other resident was also getting agitated. The resident then turned and walked back to a recliner by the nursing desk and sat down. The resident yelled at staff during the shift, slept a little, and rested in the recliner. The resident did not spend any time in his room. No further issues so far this shift.

The video footage at 4:00 a.m. showed the resident sitting in a recliner in the dayroom near the nursing station. Staff were near the nursing station. At 4:45 a.m., another resident exited his bedroom and sat next to the resident. The other resident briefly leaves with staff then returns to the recliner next to the resident and staff provide a blanket.

A second progress note written by the AP at 5:15 a.m. indicated the resident jumped out of the recliner and lunged toward the desk where all the staff were standing giving report and screamed at staff. The resident returned to the recliner but after a few minutes returned and screamed again at staff. The note described the resident as very angry and the staff were stunned. The note also indicated the AP tried to calm the resident by saying the staff were going to leave the area, and the resident sat back down in the recliner. The note indicated the resident, “is becoming a huge safety risk at this time.” At 5:35 a.m., the resident continued to sit in the recliner, laughing loudly with his hood over his head.

The video footage at 5:03 a.m. showed the resident get up from the recliner and walk to his bedroom. About two minutes later, the resident returned to the recliner. At 5:12 a.m., the resident got out of the recliner, walked towards the nursing station, without stopping turned and walked back to the recliner. Staff remained at the nursing station. Two minutes later he repeated the same action. The AP remained behind the nursing desk.

A third progress note written by the AP at 5:50 a.m. indicated the resident had been seeking out staff, going back and forth down the South Wing, yelling at two staff. Repeatedly. The note indicated the resident had not been approachable due to being so angry. At one point, he asked for coffee, which he received, but then a few minutes later stormed down the South Wing again. Other residents present were fearful and left the area. About five minutes later, an ICS was called due to the resident being out of behavioral control and being aggressive. A secondary team responded.

The video footage showed at 5:45 a.m. the resident left the recliner and sat at a table near the dining room next to another resident and then the other resident got up and left. It did not appear the resident yelled at him. A couple minutes later the resident got up and walked down the hall and back to the table. Periodically the resident paces down the hall and back to the table or the recliner. The resident does not lounge out at any staff or other residents as he passes by them.

A progress note written by ULP-1 indicated the resident had been out of his room during the night, sleeping in the recliner by the nursing station. The resident would get up to use the bathroom and return to the recliner. At about 5:15 a.m., ULP-1 had been giving report to the AP with other staff members present. The resident stood up from sitting in the recliner, walked towards staff, looked at ULP-1, and yelled obscenities at her. The resident walked away, back to the recliner to sit. After two minutes, the resident stood up, looked behind him at that wall and yelled out obscenities again. The resident turned around to look at staff, walked in a circle, and sat back down in the recliner. The resident did not have any other behaviors, and ULP-1 had no further concerns.

A progress note written by ULP-2 indicated at 5:50 a.m., she had been completing safety checks on residents. The resident started walking down the hallway toward her, but ULP-2 ignored the resident and finished the checks. While documenting the safety checks, the resident began yelling obscenities at ULP-2, but ULP-2 continued to ignore him. The resident continued to yell and walk closer to ULP-2, until she decided to walk away from the situation. Eventually, the resident walked away.

During an interview, ULP-1 stated she did not think the injection had been necessary. The resident had not been trying to attack other residents or the staff. The nurses did not try to de-escalate when the resident yelled at staff. After, the resident sat back down and stopped yelling. When the morning shift staff came in, the AP began telling them to avoid certain areas

and just go into the dining room because of the resident, but the resident had still been sitting, not saying anything. The AP radioed out the resident had been attacking staff, and they needed assistance, even though the resident had been still sitting in the chair. The AP did not tell them she called ICS, but ULP-1 could see and hear what the AP said. The secondary team responded, and someone talked with the resident. The resident walked to one of the recliners and sat, not displaying any behaviors. He laughed with one of the secondary team members, and a nurse administered the medication. A couple of the secondary team members questioned why the resident would be receiving an injection and a couple of them were upset because the AP radioed the resident had been attacking staff. When nurse-1 asked the AP if she offered him a PRN medication by mouth, the AP said no.

During an interview, ULP-2 stated around 5:00 a.m., the resident stood up from a recliner on the other side of the nursing station they were on. He stood up, cursed at the staff, sat back down, stood up, said something else, and sat back down. Less than one hour later, the resident yelled at ULP-2, but she ignored it. ULP-2 stated most of the time, if staff ignored the resident's behavior, the behavior would stop. The resident walked a couple steps closer to ULP-2, cursed at her again, and took another couple of steps. ULP-2 continued to ignore the resident. ULP-2 stated she later learned an ICS had been called, but she did not understand why. Later ULP-2 learned from another staff member the ICS had been called because the resident walked down the hall towards her, but if she had been concerned, she would have done something about it. The resident never came within arm's reach of her, and she never felt unsafe or concerned he would try to assault staff. When the ICS unfolded, ULP-2 felt confused because she and the secondary team who responded did not understand. The whole time, the AP stood behind the desk and did not say anything about it. The resident had not been assaultive or aggressive during the 30 or so minutes the ICS lasted. He talked and laughed with staff, and things were fine. Staff ordered a medication and gave it to the resident. The AP said she did not offer a PRN medication by mouth to the resident, and he had been unapproachable. ULP-2 stated the AP had given the resident a cup of hot coffee though, which made no sense if she thought he was going to assault staff. ULP-2 did not think the injection of medication had been warranted.

During an interview, nurse-1 stated she reviewed camera footage, read progress notes, and spoke with some of the staff regarding the incident. At the time the AP called an ICS for the resident being out of behavioral control, the resident had been sitting at a table for a while. The resident walked over and sat in the reclining chair, just as he had done the majority of the night. A staff member called the provider to obtain an order for the lorazepam and haloperidol injection. About half an hour later, staff approached him to give the injection. The resident did not resist and received the injection. The resident's PRN order for lorazepam by mouth had not been offered, and there were no interventions from the AP throughout the shift. Nurse-1 stated the AP orchestrated the ICS and determined the resident met criteria for the injection. The AP did not complete an assessment on the resident.

During an interview, nurse-2 stated the resident would sit down and seem okay for a while, then would walk down the hallway and yell at staff. Regarding the ICS being called, the AP did

not really discuss much with nurse-2 who worked the shift with the AP. The AP instead discussed more with the oncoming morning shift staff. Nurse-2 stated the resident probably did not need the injection at the time he received it. When the secondary team arrived, he calmed right down. Nurse-2 stated she thought they could have just stopped at that point.

During an interview, nurse-3 stated the AP reported the resident had been getting violent, threatening people all night and chasing people. The AP determined the resident needed the injection.

In conclusion, the Minnesota Department of Health determined abuse was substantiated.

Substantiated: Minnesota Statutes, section 626.5572, Subdivision 19.
"Substantiated" means a preponderance of evidence shows that an act that meets the definition of maltreatment occurred.

Abuse: Minnesota Statutes section 626.5572, subdivision 2.
"Abuse" means:
(a) An act against a vulnerable adult that constitutes a violation of, an attempt to violate, or aiding and abetting a violation of:
(1) assault in the first through fifth degrees as defined in sections 609.221 to 609.224;
(2) the use of drugs to injure or facilitate crime as defined in section 609.235;
(3) the solicitation, inducement, and promotion of prostitution as defined in section 609.322; and
(4) criminal sexual conduct in the first through fifth degrees as defined in sections 609.342 to 609.3451.
A violation includes any action that meets the elements of the crime, regardless of whether there is a criminal proceeding or conviction.
(b) Conduct which is not an accident or therapeutic conduct as defined in this section, which produces or could reasonably be expected to produce physical pain or injury or emotional distress including, but not limited to, the following:
(1) hitting, slapping, kicking, pinching, biting, or corporal punishment of a vulnerable adult;
(2) use of repeated or malicious oral, written, or gestured language toward a vulnerable adult or the treatment of a vulnerable adult which would be considered by a reasonable person to be disparaging, derogatory, humiliating, harassing, or threatening; or
(3) use of any aversive or deprivation procedure, unreasonable confinement, or involuntary seclusion, including the forced separation of the vulnerable adult from other persons against the will of the vulnerable adult or the legal representative of the vulnerable adult unless authorized under applicable licensing requirements or Minnesota Rules, chapter 9544.
(c) Any sexual contact or penetration as defined in section 609.341, between a facility staff person or a person providing services in the facility and a resident, patient, or client of that facility.
(d) The act of forcing, compelling, coercing, or enticing a vulnerable adult against the vulnerable adult's will to perform services for the advantage of another.

Mitigating Factors considered, Minnesota Statutes, section 626.557, Subd. 9c(f):

(1) The AP did not follow an erroneous order, direction or care plan with awareness and failure to take action.

The AP directed an erroneous order, direction, or care plan.

(2) The facility was in compliance with regulatory standards.

The facility provided proper training and/or supervision of staff.

The facility provided adequate staffing levels.

The AP failed to follow the facility directive and/or policies and procedures.

(3) The AP failed to follow professional standards and/or exercise professional judgement.

The AP failed to act in good faith interest of the vulnerable adult.

The maltreatment was not a sudden or foreseen event.

Vulnerable Adult interviewed: No. The resident declined to interview.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: No. The AP did not complete scheduled interview.

Action taken by facility:
The facility completed an internal investigation of the incident.

Action taken by the Minnesota Department of Health:
The facility was issued a correction order regarding the vulnerable adult's right to be free from maltreatment.

You may also call 651-201-4200 to receive a copy via mail or email

The responsible party will be notified of their right to appeal the maltreatment finding. If the maltreatment is substantiated against an identified employee, this report will be submitted to the nurse aide registry for possible inclusion of the finding on the abuse registry and/or to the Minnesota Department of Human Services for possible disqualification in accordance with the provisions of the background study requirements under Minnesota 245C.

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
The Minnesota Board of Nursing
Nicollet County Attorney
St. Peter City Attorney
St. Peter Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25494	A. BUILDING: _____ B. WING _____	C 09/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STATE OPERATED PSYCHIATRIC NURSING FA	100 FREEMAN DRIVE ST PETER, MN 56082

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: ******ATTENTION****** STATE NURSING HOME CORRECTION ORDER In accordance with Minnesota Statute, section 144.651 and Minnesota Rules, chapter 4658,	2 000	The Minnesota Department of Health documents the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes. The assigned tag number appears in the	

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	25494	A. BUILDING: _____ B. WING _____	C 09/11/2025

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2 000	Continued From page 1 these correction orders are issued pursuant to a complaint investigation. Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: HL254945229C/HL254942902M On September 11, 2025, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction order is issued. At the time of the complaint investigation, there were 29 residents receiving services under the provider's Nursing Home license. The following correction order is issued for HL254945229C/HL254942902M, tag identification 1850.	2 000	far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule number out of compliance are listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings, which are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the evaluators' findings, are the Suggested Method of Correction and the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN, WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	
21850	MN St. Statute 144.651 Subd. 14 Patients & Residents of HC Fac.Bill of Rights Subd. 14. Freedom from maltreatment. Residents shall be free from maltreatment as defined in the Vulnerable Adults Protection Act. "Maltreatment" means conduct described in section 626.5572, subdivision 15, or the intentional and non-therapeutic infliction of physical pain or injury, or any persistent course of conduct intended to produce mental or emotional distress. Every resident shall also be free from	21850		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STATE OPERATED PSYCHIATRIC NURSING FA	100 FREEMAN DRIVE ST PETER, MN 56082

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21850	Continued From page 2 non-therapeutic chemical and physical restraints, except in fully documented emergencies, or as authorized in writing after examination by a resident's physician for a specified and limited period of time, and only when necessary to protect the resident from self-injury or injury to others. This MN Requirement is not met as evidenced by: The facility failed to ensure one of one residents(s) reviewed (R1) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and an individual person was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	21850		