

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: H00578562M

Date Concluded: June 8, 2026

Compliance #: H00579062C

Name, Address, and County of Licensee

Investigated:

Abbott Northwestern Hospital
800 East 28th Street
Minneapolis, MN, 55407
Hennepin County

Facility Type: Hospital

Evaluator's Name: Kris Detsch, 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 alleged perpetrator (AP) abused a patient when he physically brought him down to the ground and restrained him (held him) after the patient threw crackers at a nurse.

Investigative Findings and Conclusion:

The Minnesota Department of Health determined abuse was substantiated. The AP was responsible for the maltreatment. Although the patient threw crackers at the nurse, the nurse was behind a glass barrier and safe from harm. The AP failed to use a measure of least harm and restrictive intervention when the AP immediately “tackled” the patient and brought him to the ground. The AP’s actions caused an immediate response from additional personnel who then gave the patient an intramuscular (IM) injection of anti-psychotic medication for an unnecessary chemical restraint. The patient’s behavior did not pose an imminent threat of harm to himself, or others and did not warrant a physical or chemical restraint. Additionally, the AP’s actions were not consistent with the hospital’s policies.

The investigator conducted interviews with facility staff members, including administrative staff and nursing staff. The investigation included review of the patient records, hospital records, facility internal investigation, facility incident reports, personnel files, and related facility policy and procedures.

The patient admitted to the hospital emergency room (ER) due to mental health concerns. The hospital then admitted the patient into their mental health unit. The patient's diagnoses included mood disorders and street drug use. Hospital records indicated the patient was alert and orientated. The patient communicated his needs verbally.

Hospital records indicated the patient became agitated over toileting issues and began to yell at the nurse. The patient became angry and threw his crackers at the window in front of her. The records indicated the nurse called a "code." Other personnel arrived and gave the patient IM antipsychotic medication. The records lacked any details about a "take down," or his behavior which prompted an IM injection of anti-psychotic medication.

Hospital internal investigation records indicated the AP used excessive force. The records indicated the AP used a "football-style tackle" on the patient. The records described the patient as "slow-moving" dependent on a walker. The records indicated the AP's actions were contrary to the hospital's policies and one person "takedowns" were unapproved.

During an interview, a manager described the mental health unit as a "U" shaped "pod" with the nursing station in the middle. Protective glass enclosed the nursing station, but there were "openings" (approximately four inches) so staff and patients could transfer items back and forth. The manager said there were two staff members in the unit at the time of the incident (the AP and a nurse). The manager said he watched the video footage from the incident. Video footage showed the patient leave his room with a walker as the AP held his door open. Video footage showed the patient walk to the nursing station where the nurse was located behind the protective glass. The AP was not visible on video at this time, so the AP was about four feet away from the patient. Video footage showed the nurse put crackers on top of the desk so the patient could reach them. The patient took the crackers but then threw them toward the nurse. Video footage showed the patient grab his walker, take about two steps as he turned toward his room. At this time, the AP then took the patient down to the ground. The manager described the "take down" as a "tackle." The manager said video footage showed the AP hold the patient down on the ground until other personnel arrived about thirty seconds later. The manager said the patient was not fighting with the AP as he lay on the ground. The manager said the nurse pushed the emergency button after the AP took the patient to the ground. This is what prompted emergency personnel to arrive. Once emergency personnel arrived, they gave the patient an IM injection of anti-psychotic medication. The manager said the AP's actions were inappropriate because the patient was not a threat to himself or staff. The manager said the AP's actions were not consistent with the hospital's policy, because they did not train their staff to perform one person "takedowns." The manager said the AP should have disengaged from the situation and walked away.

The nurse failed to respond to request for an interview, or subpoena. In a prior statement to on-site surveyors, the nurse said she did not see the incident happen, but it “felt pretty instantaneous.”

Employee file records indicated the AP also violated the hospitals restraint policy which allowed staff to use restraints only when the patient’s behavior created an immediate risk of physical harm to others, or themselves. The records indicated the AP acknowledged he did not use de-escalation techniques or less restrictive interventions.

During an interview, the AP said the patient wanted to use a urinal, but the nurse would not let him. The AP said this agitated the patient. The AP described the nursing station as a “bubble.” The AP said the nurse was in the bubble as the patient stood outside the bubble. The AP said he was about three to four feet away from the patient. The AP said he saw the patient throw an item at the nurse, but then he turned toward him (the AP). The AP said the nurse did not respond or give him any verbal directions, so he went “hands on” and took the patient to the ground. The AP said he had full control of the patient as he took him to the ground, and the patient did not hit his head. The AP said he took the patient to the ground “gently” and talked to him the entire time. The AP said he did not push his emergency button because he left it behind the nursing station. The AP said he held the patient on the ground until other emergency personnel arrived. The AP said emergency personnel gave the patient a “shot,” then he helped the patient off the ground. Then the patient walked back into his room. The AP said the patient was cooperative when he was on the ground and asked him why this event occurred. The AP said the patient seemed upset about the whole situation. The AP said it only took about thirty seconds from the time the patient threw the item, before he took him down to the ground. The AP said this was not his first “take down” by himself. The AP said staff should retreat if they could, and wait for security or other personnel to arrive. The AP said he felt he had no other option other than to perform the “take down” because the patient’s behavior was threatening.

During an interview, the patient said he went to the hospital due to withdrawal from street substances. The patient said his body was painful during this process and it was difficult for him to move around. The patient said he wanted to use a urinal; however, the nurse would not allow it, and he had subsequent incontinent episodes. The patient said he got upset, and “tossed” an item at the window. The patient said the AP “instantly” grabbed him with all his force and “slammed” him to the ground. The patient said other personnel arrived and gave him an IM injection (antipsychotic medication) while he was on the ground. The patient said he was calm and compliant when he was on the ground. The patient said he got up, then walked back to his room but he was fearful the AP would “beat on him” again. The patient said the medication made him feel horrible and it took days for him to stop feeling sleepy. The patient said he felt like crying because of what the AP put him through, and he did not want this to happen to anyone else.

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;

(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; and

(4) use of any aversive or deprivation procedures for persons with developmental disabilities or related conditions not authorized under section 245.825.

(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 patient, 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.

Vulnerable Adult interviewed: Yes.

Family/Responsible Party interviewed: Attempted.

Alleged Perpetrator interviewed: Yes.

Action taken by facility:

The facility provided re-education to employees regarding policy and procedures. The AP is no longer employed at the facility.

Action taken by the Minnesota Department of Health:

MDH previously investigated the issue during a complaint survey under federal regulations, and substantiated facility noncompliance. To view a copy of the Statement of Deficiencies and/or correction orders, please visit:

<https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html>. You may also call 651-201-4200 to receive a copy via mail or email.

The purpose of this investigation was to determine any individual responsibility for alleged maltreatment under Minn. Stat. 626.557, the Maltreatment of Vulnerable Adults Act.

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

Hennepin County Attorney

Minneapolis City Attorney

Minneapolis Police Department

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00242A	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/12/2026
NAME OF PROVIDER OR SUPPLIER ABBOTT NORTHWESTERN HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 800 EAST 28TH STREET MINNEAPOLIS, MN 55407		
(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
6 000	INITIAL COMMENTS The Minnesota Department of Health investigated an allegation of maltreatment, complaint H00578562M, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557. The following correction order is issued/orders are issued for H00578562M, tag identification 1850.	6 000			
61850	MN St. Statute144.651 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 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 patients reviewed (P1) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH)	61850			

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health

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61850	Continued From page 1 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.	61850			