Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: H00018444M
Compliance #: H00014972C

Date Concluded: June 18, 2024

Name, Address, and County of Licensee Investigated:
North Memorial Health
3300 Oakdale Avenue North
Robbinsdale MN, 55422
Hennepin County

Facility Type: Hospital

Evaluator's Name: Kris Detsch, RN
Special Investigator

Finding: Not Substantiated

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 shouted at him to "lay the fuck down," while shoving him down onto his bed. Additionally, the AP made the patient wear urine soiled clothing for approximately twelve hours.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was not substantiated. Although the AP used profanity and her conduct was unprofessional, the conduct did not meet the definition for emotional abuse. Staff reported the AP was rough in the way she handled the patient's items but did not witness the AP shove the patient. The patient, during the two hour behavioral episode, insisted on wearing his pants despite being soiled. Whereas, the AP did put the patient's soiled pants back on him, other staff did not remove them when they provide care either.

The investigator conducted interviews with facility staff members, including administrative staff, and nursing staff. The investigation included review of hospital records, and surveyor documentation completed at the facility during the initial investigation.

The incident occurred while the patient was at the hospital in the medical intensive care unit (ICU). His diagnoses included end stage renal disease, stroke, and diabetes.

Hospital records indicated the patient lived in a group home, but they sent him to the hospital because his level of consciousness changed. He was unresponsive in the emergency room (ER) and his lab values were abnormal. Physicians determined his illness was critical (life-threatening) and the patient admitted to the intensive care unit (ICU). The patient required emergency dialysis.

Hospital documentation from nursing staff indicated the patient began to respond to treatments and was awake the following day. By the afternoon, a nurse documented she had multiple conversations with the patient because he wanted to go home, but he responded to her by using foul language. The AP worked the following shift and her documentation indicated she had similar conversations with him. The AP's documentation indicated he yelled and cursed at her, refused to participate in cares, and spit out his medications. He also attempted to get up and leave. The AP documented the patient required a "roll vest" (restraint), and medication to sedate him.

The patient's medication administration record (MAR) indicated the nurse manager ordered the "roll vest" restraint for the patient at the start of the AP's shift. Approximately two hours later nurse #1 gave the patient a medication for anxiety approximately the same time the AP received an order from a physician to give the resident a medication for continuous sedation.

During an interview, a nurse manager said she worked alongside the nurses in the ICU and assisted them with providing cares. She said when she came on shift, she received a report from another nurse about the patient. The patient attempted to get out of bed, which was unsafe for him to do, so she made the decision to get a "roll vest" restraint for him. The nurse manager said then she went to another room to help a nurse with a different patient who was critically ill. While she was in the different room, the AP approached her and said, "I can't fucking do this." The nurse manager said she directed another nurse to help the AP because she could not leave the room. Once she was able to leave, the nurse manager went to the patient's room and saw two nurses (#1 and #2) put the "roll vest" restraint on him. The nurse manager said the patient was very agitated, used foul language, and attempted to hit the staff. At this time, the AP was at the nurse's station calling the physician to get medication for him. The nurse manger asked the AP if she wanted to switch patient assignments, but the AP declined. The nurse manager said it was later during the evening when nurse # 1 told her she overheard the AP hollering at the patient earlier in their shift. The nurse manager was not sure how to handle the situation, so she "hovered" around the AP as she provided cares to the patient throughout the shift, and there were no further incidences. The nurse manager said there was a concern from

staff about the patient's shorts, but she could not recall the details. The nurse manager said there was nothing reported to her about a physical altercation between the AP and the patient. The nurse manager said she observed the patient during the shift, and he appeared to be resting comfortably. The nurse manger said she worked with the AP frequently and had no concerns about her being rough with a patient, but the AP was easily frustrated. The nurse manager said she did not think the hospital should assign new nurses to work in the ICU. The nurse manager said after her shift she sent an email to the unit manager about the incident.

During an interview, a unit manager said she received an email from a nurse manager who worked the night of the incident. The email indicated the nurse manager was concerned about things she heard from staff and observed regarding the AP's behavior. The email indicated a nurse (nurse #1), walked by the patient's room, and overheard the AP shouting at the patient with profanity such as, "shut the fuck up and settle the fuck down." The email indicated nurse #1 observed the AP use her forearm to shove the patient down into the bed in an aggressive manor. The unit manager said she completed an investigation once she received the email. She spoke to nurse #1 who confirmed she overheard the AP shout at the patient and thought the shift the AP was aggressive toward him. Nurse #1 explained the AP's aggression was with items in his room, such as how she adjusted bedding, or a pillow, nothing physical toward him. No other staff members reported they witnessed any physical contact from the AP to the patient. The unit manager said at some point the patient focused on his clothes and he wanted his pants, but the AP told him he "pissed" himself and they were wet. The patient insisted he needed his pants, so the AP put them on him. Nurse #1 and nurse #2 told the unit manger they went to reposition the patient and his pants were wet, but neither nurse #1 or nurse #2 removed the pants and the unit manager did not ask why. This series of events occurred within an approximate two-hour time frame. During this time frame, nurse #1 and nurse #2 provided care to the patient including calling physicians and giving him medication. The AP continued to provide care for the patient for her entire shift and there were no further incidences or complaints about the AP's behavior toward him. The unit manager said prior to this incident, there were no other concerns about the AP's work performance. The unit manager said the AP appeared "frazzled", but nothing concerning for harm. The AP was a new nurse and started working in the trauma neuro pediatric ICU (specialized unit), but this was challenging for her, so she transferred to the medical ICU. At the time of the incident, the AP was a nurse for one year. The unit manager placed the AP on leave, then terminated her.

Nurse # 1 did not respond to request for interview.

Nurse # 2 declined to interview.

A surveyor from the Minnesota department of health (MDH) completed an onsite visit at the hospital. The surveyor's documentation indicated a nursing assistant who worked during the incident said the patient's clothing smelled like urine, so she washed them by hand, and left them to "air" dry. This occurred before staff applied the "roll vest" restraint. At the time staff

applied the “roll vest” restraint, the patient was wearing a hospital gown. The nursing assistant then left the room to assist another patient.

During an interview, the AP said the patient was unable to walk and required a wheelchair. He attempted to get out of bed, which was dangerous for him. The AP said a nurse manager from the prior shift determined he required a “roll vest” restraint. The AP and another staff member placed the “roll vest” restraint on him, but he remained agitated and continued to attempt to get out of bed. The AP said the patient cussed at her and called her derogatory names because he wanted to leave, and wanted his clothing. The AP said she applied firm boundaries by repeating back to him what he told her and how inappropriate it was. The AP said the patient’s clothing was dry when she put it on him. The AP said she did not hit or shove the patient and any foul language she used she did not direct it toward him. The AP said at the time of the incident, she worked as a nurse less than one year.

In conclusion, the Minnesota Department of Health determined abuse was not substantiated.

“Not Substantiated” means:
An investigatory conclusion indicating the preponderance of evidence shows that an act meeting the definition of maltreatment did not occur.

Abuse: Minnesota Statutes section 626.5572, subdivision 2.
"Abuse" means:
(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;

Vulnerable Adult interviewed: No, unable due to memory loss.
Family/Responsible Party interviewed: No. Declined interview.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility removed the AP and investigated the incident.

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.

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00240	A. BUILDING: _____ B. WING _____	C 04/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH MEMORIAL HEALTH	3300 OAKDALE NORTH ROBBINSDALE, MN 55422

(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 #H00018444M, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557. No correction orders are issued. The facility is enrolled in the electronic Plan of Correction (ePoC) and therefore a signature is not required at the bottom of the first page of the State form. Although no plan of correction is required, it is required that you acknowledge receipt of the electronic documents.	6 000		