

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: H00043244M
Compliance #: H00049541C

Date Concluded: September 15, 2026

Name, Address, and County of Licensee

Investigated:

Hennepin County Medical Center
701 Park Avenue
Minneapolis, MN, 55415
Hennepin County

Facility Type: Hospital

Evaluator's Name: Willette Shafer, 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 the patient when the AP slapped the patient in the face after the patient spit at the AP.

Investigative Findings and Conclusion:

The Minnesota Department of Health determined abuse was substantiated. The AP was responsible for the maltreatment. The AP admitted to slapping the patient in the face after the AP spit at him. The incident was also observed by unlicensed personnel who was in the patient's room at the time of the incident. After a nurse outside the patient's room heard a slapping sound, she entered the patient's room, and the patient reported the AP hit him in the face.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the patient's family member. The investigation included review of the resident records, facility internal investigation, facility incident reports, personnel files, staff schedules, and related facility policy and procedures.

The patient was admitted to the hospital for a potential drug overdose or drug withdrawal crisis. The patient was diagnosed with swelling in his brain and severe agitation. In the days leading up to the incident, the resident was physically aggressive towards himself and others. The medical provider ordered restraints for safety and one-to-one staffing to monitor the patient.

The patient's medical record indicated during the incident the patient was in critical condition due to encephalopathy (condition that causes brain dysfunction) and respiratory failure. At the time of the incident the patient was recently extubated (breathing tube removed), had a feeding tube, a urinary catheter, an intravenous (IV) catheter, and an open wound on his heel. The patient also had a 102 degrees Fahrenheit fever shortly before the incident.

The internal investigation indicated the AP attempted to administer medications to the patient. Unlicensed personnel reported the patient was agitated about medications and spit towards the AP. Unlicensed personnel reported the AP "punched the patient in the face/head". After the incident, the patient told unlicensed personnel he was hit three other times in the past. During the incident, nurse-1 was in the "team center" outside the patient's room when she heard a "slap." When nurse-1 entered the patient's room, the patient said "you slapped me. I want to file charges." Nurse-1 and the AP reinforced the patient's wrist restraints and left the room. Nurse-1 reported the AP admitted to slapping the patient and reported it was "an instinctual reaction." During the AP's internal investigatory interview, he described entering the patient's room to administer medications. The AP said the patient tried to hit him (patient had wrist restraints on and bound to bed rails). The AP put his hand over top of the patient's hand to prevent him from moving it and the patient spit at the AP. The AP gave a visual demonstration of his actions by making a slapping motion with his hand and described his reaction as "reflexively." The AP said nurse-1 entered the patient's room and they discussed completing an incident report. During a follow-up interview three days after the incident, the AP reported the patient's "mucus" was in his eyes. There was no mention of an exposure report completed or follow-up care completed.

During an interview, the unlicensed personnel said she was assigned to provide constant supervision to the patient. While the AP gave the patient his medication the resident spit at the AP. Then the AP hit the patient in the head near his face. She was unsure if the AP hit the patient with an open or a closed hand but described the strike as "fast" and she heard a "boom" sound. She said after the AP hit the patient; the patient began crying. She said, "I felt so bad" and "it broke my heart." She said she reported the incident and her observations to management.

During an interview, nurse-1 said she was at the nurse's desk outside of the patient's room roughly "30 plus feet away." She said the patient had loose wrist restraints on and "mitts" (soft, thick padded mittens) on hands. She said she observed the patient flailing his hands, the AP moved his head back, and then she heard a slapping sound. As she heard the slapping sound

she observed the AP make a slapping motion towards the patient. She entered the patient's room and the patient said, "he hit me!" The nurse said the AP admitted to hitting the patient and left the room. The nurse said the unlicensed personnel observed the incident and reported the AP hit the patient after the patient spit towards the AP. The nurse said she reported the incident to management who completed an internal investigation.

The AP reported the resident had recently been extubated and was hungry and thirsty. He said he was waiting for speech therapy to assess and approve fluids for the resident as the resident "really wanted something to drink." The AP said the patient was agitated and hitting his hand against the bedrail. He said he put his hand on top of the patient's hand to prevent him from injuring himself. The AP acknowledged the patient had wrist restraints and mitts on his hands while hitting the bedrail. The AP reported the patient spit towards him and spit got in his eyes. He said he could not see and "swatted" towards the patient to protect himself. The AP "swatted" the patient in the head with an "open hand" as a reaction to the patient spitting towards him. He said the incident was observed by unlicensed personnel present in the room and nurse-1 who was outside the room responded immediately. He told nurse-1 he would report the incident. Management conducted an internal investigation. The AP said he washed his eyes out but never sought follow up testing or treatments.

During an interview, a member of management, who was also a nurse, said the incident was witnessed by unlicensed personnel who was assigned to monitor the patient. The unlicensed personnel reported the patient spit in the AP's face, and the AP slapped the patient in the head. He said a nurse heard the slap and responded to the patient's room where the incident was reported to the nurse. The nurse told the AP the incident must be reported. The nurse and the AP reinforced the patient's wrist restraints. The member of management completed internal investigation and interviewed staff members involved. He said the AP received various training on vulnerable adult maltreatment, and patient safety before the incident. The member of management attempted to interview the patient a few times, but the patient was sedated during each attempt. During a follow up interview three days after the incident, the AP reported the patient's "mucus" got in his eyes. The AP failed to report a potential exposure, saliva in his eyes, during the initial interview. The member of management said the AP was not concerned about potential exposure during the follow-up interview, but he was concerned with his reaction towards the patient.

The hospital's Bloodborne and Other Pathogen Exposure Control Plan indicated when a blood/body fluid exposure was identified, an exposure analysis report was completed and follow up monitoring, testing, and vaccines are offered to the healthcare worker.

The AP's training record indicated the AP completed Vulnerable Adult Maltreatment training along with various other patient safety trainings before the incident.

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.

Vulnerable Adult interviewed: No, unable to reach him as he does not have a phone or housing.

Family/Responsible Party interviewed: No. Family member declined the interview. She was unaware of the incident and had no information to add.

Alleged Perpetrator interviewed: Yes.

Action taken by facility:

The facility completed an internal investigation and initiated standard protocol based on the information.

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 Board of Nursing

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00211	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/29/2026
NAME OF PROVIDER OR SUPPLIER HENNEPIN COUNTY MEDICAL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 701 PARK AVENUE MINNEAPOLIS, MN 55415		
(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 H00043244M, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557. The following correction order is issued for H00043244M, tag identification 1850.	6 000	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 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.		
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	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 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 patient reviewed (P1) 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.	61850			