Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: H00802904M
Compliance #: H00802944C

Date Concluded: June 23, 2023

Name, Address, and County of Licensee Investigated:
University of Minnesota Medical Center
2450 Riverside Ave.
Minneapolis, MN 55454
Hennepin County

Evaluator's Name: Lissa Lin, RN
Special Investigator

Facility Type: Hospital

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 the patient when he restrained her using a basket hold, pushed her onto a bed and yelled at her.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was not substantiated. The AP used an approved behavioral emergency response technique (BERT) to intervene when the patient physically assaulted another other staff member. During the intervention, the AP and the patient struggled, fell onto the patient's bed, and she hit the AP in the eye. The AP used a loud voice and told the patient not to hit him. The patient was unharmed.

The investigator conducted interviews with facility staff members, including, nursing staff and unlicensed staff. The investigator was unable to contact the patient for an interview. The investigation included review of hospital records, employee records, policies and procedures.

The patient admitted to inpatient hospital treatment due to mental health concerns and severe constipation. The patient had been in the psychiatric ward for a month. Her diagnoses included decompensated schizophrenia, post-traumatic stress disorder (PTSD), epilepsy, and falls. (Decompensated schizophrenia means the condition was managed, but then worsened). The patient was not consistently able to make her needs known and English was not her first language.

The patient's behavioral plan of care included medication administration, assault precautions, restriction to the psychiatric unit unless she had imaging procedures, elopement, fall, and seizure precautions. Two staff provided safety checks to the patient every 15 minutes.

One morning, the AP and another psychiatric associate (PA) checked on the patient. The PA went into the patient's room to talk to her while the AP stayed in the doorway. The patient swung out at the PA, who grabbed the patient's arm and a struggle started. The AP said he went into the room and performed a basket hold on the patient to keep the assault from escalating. (A basket hold required the AP to approach the patient from the side or behind and "bear hug" her so the patient's arms are restricted. Taller staff "hug" the shoulders and upper arms while shorter staff "hug" the lower arms. Then, both staff hold the patient's opposing wrist so her arms are crossed over her torso and staff can walk the patient to a bed or chair.)

The AP said the PA did not help him with the basket hold, which could be done with one or two staff members depending on the situation and it was the least restrictive hold. The AP said the patient moved one of her legs between his and tried to kick him in the groin. Two nurses arrived but did not assist him even though he said he called for help. The AP said he struggled to walk the patient over to her bed to get her seated, but they tripped and fell onto the bed. The AP landed on top of the patient. He said she was face down on the mattress but reached behind her and hit him in the left eye. The AP said he yelled at her not to hit people. The AP remained on top of her for about 5 to 10 seconds using the basket hold before he could safely let her go since she still tried to kick and hit him. The AP said he left the patient's room and went to the emergency department to get his eye examined.

During an interview, the AP said he had cared for the patient many times over eight or nine years and she was known for hitting staff with her hands. The unit he worked in cared for violent patients the other hospital units could not take. Staff members were taught many techniques, or BERTS, for de-escalation and self-defense to get away from dangerous situations. The AP said he regretted using a loud voice at the patient when he told her she could not hit people, but that was not abuse.

The AP said a manager called him about the event a few days later. He was suspended during an internal review and then returned to work with a behavioral monitoring plan and re-education. Internal review records indicated the investigation determined the AP's words to the patient were appropriate, but the tone and volume were "unprofessional".

During an interview, a nurse said when she arrived at the patient's room, the AP rushed at the patient, got her in a bear hug and pushed her into her room and onto the bed. He yelled into the patient's face "Don't you ever hit me again!" The nurse said she did not recall the AP asking for help with the patient. The nurse said the basket hold was an approved intervention for someone in imminent danger, but she felt the AP was unprofessional with the patient. She said she told the AP to let the patient go. The nurse said the patient was unharmed and returned to her baseline.

The patient's hospital records indicated the patient had physically assaulted hospital staff multiple times during her admission and treatment.

The patient was not available for an interview. Her family member declined an interview.

Additional nursing staff did not respond to emails and phone requests for interviews.

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:
(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;

Vulnerable Adult interviewed: Was not available.

Family/Responsible Party interviewed: Declined.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
AP suspended during internal investigation, returned to work with a behavioral monitoring plan and re-educated.

Action taken by the Minnesota Department of Health:
The facility was found to be in 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

If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

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

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
	00200	A. BUILDING: _____ B. WING _____	C 04/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
M HEALTH FAIRVIEW UNIVERSITY OF MN	2450 RIVERSIDE AVENUE MINNEAPOLIS, MN 55454

(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 #H00802904M, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557. No correction orders are issued.	6 000		