Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: H01152686M
Compliance #: H01155985C

Date Concluded: June 1, 2024

Name, Address, and County of Licensee Investigated:
Mercy Hospital
4050 Coon Rapids Boulevard
Coon Rapids, MN 55433
Anoka 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 a patient when the patient sustained multiple fractures to her face.

Investigative Findings and Conclusion:
The Minnesota Department of Health (MDH) determined abuse was substantiated. The AP was responsible for the maltreatment. The AP used excessive force to take a patient to the ground causing multiple facial fractures and tissue injuries to her face and body.

The investigator interviewed a family member. The investigation included review of medical records, personnel records, surveillance videos of incident, hospital and security policies and police records. The investigator also contacted law enforcement. The investigator reviewed the initial complaint surveyor's notes.

The patient was admitted to the mental health unit in the emergency department during the incident. The patient resided at home with her family before the incident and was discharged back to her family's residence after her hospital stay. The patient had multiple mental health diagnoses and was admitted for mental health crisis management.

Per hospital records, the patient's mental health declined and she became aggressive towards family members at home. The patient was placed on a 72-hour hold due to alteration in reality and danger to herself and others. At the hospital, the patient required increased observation, de-escalation, and seclusion/restraint due to her aggressive behavior. During one incident, the patient was secluded due to aggressive behavior where patient lunged at the nurse. When the nurse entered her room, the patient grabbed the nurse's arm and hand. The AP, who was also a security officer took the patient to the wall and down to the ground where security escorted the patient back to bed and placed in 4-point restraints. Later, Xray results of the patient's face indicated multiple fractures of the left orbital (facial eye) bone and left sinus cavity (cheek). The patient's medical record also indicated the patient suffered left shoulder bruising after the incident.

During an interview, a family member said when they visited the patient. She had five facial fractures, a black eye, bruised face, and her face looked deformed. A provider reported to family she sustained injuries when she fell during a restraint. Later, family requested to watch the security video footage of the incident.

The investigator submitted a subpoena to the hospital for the security video. The hospital refused to release the video to MDH for the investigation and only permitted investigators to view it at the hospital.

Review of the security video footage of the incident showed two staff members, the AP and the nurse, were observed entering the patient's room. Interactions inside the room were outside of the security camera frame. The AP and the patient came out of the room with momentum. The AP held onto the patient from behind with both hands, pushing the patient out of the doorway while a nurse was in front of patient holding onto her with both hands. While they forcefully moved forward out doorway, the nurse in front stepped aside and the patient and AP (still holding patient from behind) slammed into wall across the hall from doorway. The patient hit the wall with the AP holding onto her behind her. The AP forcefully lifted and turned the patient from wall to the ground with enough force to lift the patient's feet off ground. The patient hit the ground on with her chest and left side of her face first with the AP landing on top of the patient with all his weight. While the patient was on the ground, stomach side down, the AP mounted the resident, sitting on top of her and applied hand cuffs. Several staff watched the incident idly. One staff wiped blood off the floor and off patient's face while the AP applied handcuffs.

According to the MDH federal surveyor's notes, during multiple interviews with nursing staff, staff said the AP threw the patient to the ground and handcuffed her. The AP's personnel file

indicated the AP received corrective action in previous “Use of Force” investigations. Interviews by the MDH surveyor revealed patient care staff and security staff were aware handcuffs were not patient care interventions.

During an interview, the AP said he was called for a show of support because the patient was standing on her bed. The patient was in seclusion, across the hall from the nurse’s station at the time of the incident. All sharps and weapons were removed from the patient’s room during seclusion. A nurse, unlicensed personnel (ULP), and AP entered patient’s room. Nursing staff told the patient they needed to remove her bed from her room. The patient became upset and grabbed at nurse in doorway. AP stated he grabbed patient to escort her to wall (located across the hall from patient’s room). He said he couldn’t gain control as they were trained to use the “wall hold” with two people. He took patient to the ground and applied handcuffs. He said they were trained to bring patient to ground as safely as possible. He said he applied handcuffs because ambulatory restraints weren’t available. Ambulatory restraints were in nurse’s station located across the hall from the resident’s room.

The nurse failed to respond to interview requests.

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;
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;

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 facility did not direct an erroneous order, direction, or care plan.

(2) The facility was not 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 unforeseen event.

Vulnerable Adult interviewed: No, declined interview due to trauma of event.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The employee no longer works at the hospital.

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
Anoka County Attorney
Anoka City Attorney
Fridley Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00009	A. BUILDING: _____ B. WING _____	C 04/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERCY HOSPITAL	4050 COON RAPIDS BLVD COON RAPIDS, MN 55433

(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 #H01152686M, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557. The following correction order is issued for #H01152686M, tag identification 1850.	6 000	Tag numbers have been assigned to Minnesota state licensure rules for hospitals. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the Minnesota Department of Health is documenting the State Licensing Correction Orders using federal "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is 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.	
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	61850		

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61850	Continued From page 1 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(s) reviewed (P1) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, 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	No plan of correction is required for this tag.	