Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: H02142740M
Compliance #: H02144629C

Date Concluded: May 30, 2024

Name, Address, and County of Licensee Investigated:
Maple Grove Hospital
9875 Hospital Drive
Maple Grove MN 55369
Hennepin County

Facility Type: Hospital

Evaluator's Name: Holly German, 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 the AP threw the patient to the ground and pulled the patients hair.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was not substantiated. While the AP did place the patient on the ground, he followed policy and protocols. The patient physically assaulted another medical staff member, and the AP responded to ensure the safety and protection of the assaulted staff member, himself, the patient, and others.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and security staff. The investigation included review of the resident records, hospital records, facility internal investigation, facility incident reports, personnel files and training records, staff schedules, related facility policy and procedures. Also, the investigator observed video footage of the incident.

The patient admitted to the emergency room for a mental health crisis and suicide attempt. The patient's diagnoses included depression and intentional overdose of medication. The medical provider ordered an emergency medical hold for her safety with continuous staff observation. The patient's emergency room assessment indicated the patient was lethargic with acute confusion and had impaired judgement. The assessment indicated the patient was cooperative.

The nurse's notes indicated the patient had remained calm and cooperative during her admission prior to notification of facility transfer.

The hospital internal investigation indicated the nurse escorted the patient to the bathroom in the hallway outside of the patient's room. Upon exiting the bathroom, the patient walked past the door to her hospital room, continued down the hallway and went out the door of the hospital with the nurse behind her. The nurse called security for assistance. The AP, a security officer (SO), and SO 1 attempted to verbally redirect the resident back in the hospital. The patient punched SO 1 in the stomach. The AP and SO 1 began to escort the patient back to the hospital. As SO 1 reached out to open the door to the hospital, the patient punched him on the back of his head. In response, the AP used a takedown maneuver to place the patient on the ground. The AP and SO 1 assisted the patient to her feet and escorted her back to her hospital room.

The resident's hospital record indicated the resident remained calm after returning to her room from her elopement attempt. The record lacked evidence of injury sustained to the patient, or complaint stated from the patient related to the AP or SO 1. The nurse's notes did not indicate an injury or concern voiced by the resident upon return to her room after eloping.

The provider notes indicated the provider medically cleared the patient for facility transfer and also did not indicate an injury or concern related to the elopement incident.

Review of video footage showed the patient hit SO 1 in the back of his head, and the AP placed the patient on the ground by physical force while he had a hold of her arm. The video footage did not show the AP nor SO 1 had placed their knee or body weight on the patient. The patient was on the ground for 33 seconds before the AP and SO 1 assisted her back up on her feet. The video showed the patient walked cooperatively back into the hospital escorted by the AP, SO 1, and the nurse. Review of the video footage did not reveal any signs of blood or a cut to the patient's wrist.

During an interview, the AP stated he received defensive tactic training as required. The AP stated the security staff are directed by the medical staff to return an eloped patient to the hospital. The AP stated he received a call to assist SO 1 in the return of the patient. While the AP and SO 1 escorted the patient back to the hospital, the patient hit SO 1 on the back of his head with a full swing. The AP stated he placed the patient on the ground using a takedown maneuver to protect SO 1, himself and the patient. The AP stated the patient cooperated with

walking back to her hospital room after the incident. The AP stated he was not aware if the patient sustained any injury.

During an interview, SO 1 stated the patient punched him in the stomach before the arrival of the AP to the scene. SO 1 stated he and the AP then escorted the patient back towards the hospital, and when his back was turned toward the patient so he could open the door, she hit him on the back of his head, and caused him to fall to the ground. SO 1 stated when he came back to consciousness, the AP had the patient on the ground in a take down hold. SO 1 stated he and the AP then escorted the patient back to her hospital room. SO 1 stated proper procedure was followed during the incident.

During an interview, the nurse stated the resident did not sustain any injury related to the incident with the AP and SO 1. The patient did not voice any concern to her about the incident.

During an interview, SO 2 stated all security officers go through orientation that included skills training and checklist, online training, policy review, and shadow training with another officer prior to working independently. SO 2 stated based on the actions of the patient and the situation, the AP and SO 1 appropriately completed the task of returning the patient to the hospital.

During an interview, the patient stated she struggled with her mental health and had admitted herself to the hospital for help. The patient stated she went outside knowing she was not supposed to, and that she was not in her right mind. The patient stated she hit SO 1 in the stomach when he grabbed her by the arm. The patient stated SO 1 threw her on the ground and put his knee in her back. The patient did not recall the AP being present. The patient stated her wrist sustained a cut during the incident. The patient denied hitting SO 1 in the head. The patient stated she did not voice concerns to the hospital staff about how the AP or SO 1 treated her during the incident because she felt the staff did not care what she said.

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;
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;

Vulnerable Adult interviewed: Yes.
Family/Responsible Party interviewed: No, patient is own responsible party.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
No action required.

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
	25593	A. BUILDING: _____ B. WING _____	C 04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE GROVE HOSPITAL	9875 HOSPITAL DRIVE MAPLE GROVE, MN 55369

(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 #H02142740M, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557. No correction orders are issued.	6 000		