Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: H40022562M, H40022527M

Date Concluded: November 21, 2023

Name, Address, and County of Licensee Investigated:
Anoka Metro Regional Treatment Center
3301 7th Avenue North
Anoka, MN 55303
Anoka County

Facility Type: Hospital

Evaluator's Name: Carol Moroney RN, Special Investigator
Rhylee Gilb, 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 patients (patient 1 and patient 2) when the AP used an inappropriate manual hold by lifting patient 1 and patient 2 off the ground and bringing the patients directly to the ground.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was not substantiated. The AP's use of a manual hold was done with due care for patient 1 and patient 2 in response to threats and aggression. Although, the AP failed to follow the correct manual hold procedure by not lifting patient 2 off the ground, it was an error in therapeutic conduct. During the hold with patient 1, security video showed patient 1's feet were touching the ground prior to the AP bringing

patient 1 to the ground. The manual hold technique and lowering a patient to the ground was a part of the facility's de-escalation procedures.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and security staff. The investigator also contacted law enforcement. The investigation included review of patient 1 and patient 2's medical records, incident reports, grievances, and policies and procedures related to the event.

The safety support staff's job duties included de-escalation in an imminent risk of harm situation utilizing the EASE Foundations: Physical Safety Strategies program. The technique included approach from behind to hold the patients arms at their side or across their body. When engaged in this hold, instruction included escorting the patient backwards to prevent them from raising their feet. Further instruction included moving a patient to a seated position and to the ground if the need arises for safety.

PATIENT 1

Patient 1 admitted to the facility due to incompetence from incarceration for assault on a "Rule 20" (allows inmates time at a mental health facility count towards sentenced time served) court order. Patient 1's preadmission assessment indicated his diagnoses included Schizophrenia, however he was not on medications. Patient 1's behaviors included physically aggressive and violent.

Patient 1's incident report indicated patient 1 arrived at the facility for admission. During security screening, patient 1 made verbal threats to harm pregnant women. Patient 1 disrobed and became agitated when instructed to put his pants on. Patient 1 took off running from the intake area and out into the main courtyard. Patient 1 refused to comply with verbal direction. Staff activated incident command. The AP, a safety support staff, arrived in the courtyard, came up behind patient 1 and engaged in a manual hold. Patient 1 head butted the AP and continued to resist. The AP brought patient 1 to the ground for restraints to be applied. Patient 1 did not have any injury.

Review of the security video footage of the intake area and courtyard. The video showed patient 1 run from the intake area out of a door and the next video showed patient 1 running in the courtyard with four staff following him. The patient stopped and turned to face the staff, while walking backwards. The AP came up quickly behind patient 1, wrapped his arms around patient 1 to keeps his arms at the side. Additional activity of the AP's manual hold on patient 1 took place obstructed from camera view by a light pole, however patient 1 had on blue shoes and movement of his shoes were visible. Patient 1's right legged lift at one point, but then both feet were on the ground, when the video showed the AP move patient 1 to the ground in a side lying hold.

PATIENT 2

Patient 2 admitted to the facility due to incompetence from incarceration for assault on a “Rule 20” court order. Patient 2’s preadmission assessment indicated his diagnoses included Schizophrenia and refused to take medications. Patient 2’s behaviors included eating non-edible items, aggressive, disorganized thinking, and delusional thoughts.

Patient 2’s incident report indicated patient 2 arrived at the facility for admission. During security screening patient 2 disrobed and made delusional statement with clenched fists. The AP and other safety support staff escorted patient 2 towards the intake unit. Patient 2 stated he would hurt anyone who touched him while making a gun gesture with his hands. While walking, patient 2’s pants fell down, the AP pulled up patient 2’s pants, in which patient 2 stated “thank you for pulling my pants up” but then got close to the AP’s face with a closed fist and started screaming. The staff place patient 2 in a manual hold while patient 2 continued to be combative and kick. Staff applied restraints to patient 2 and required intramuscular injection of anti-psychotic medication. Patient 2 had a reddened area on his left shoulder that “appeared to be a rug burn” and no other injuries.

Review of the security video footage of the hallway and unit entrance showed patient 2 walking down the hall with four staff, one of which was the AP, who was position between the wall and patient 2. The video showed patient 2’s pants fall to his ankles and the AP lift patient 2’s pants up with no further contact from the AP. Patient 2 then made a closed first, raised towards the AP in a punch motion and then jumped his body into the AP. The AP, along with two other staff began to maneuver a manual hold. While conducting the hold, staff struggled to get patient 2 contained. The AP was able to get correctly positioned behind patient 2 in the manual hold with patient 2’s arms pressed down against his side. Patient 2 continued to resist and lunged forward with the AP falling forwards with patient 2. The AP then flung backward which lifted patient 2 off the ground. The AP walked about 10 feet forward towards the unit with patient 2’s feet lifted off the ground. Patient 2 then lifted his legs up to kick off the closed door of the unit causing him and the AP to fall towards the wall. It was unclear if they hit the wall, but another camera angle showed the momentum caused the AP to spin backwards slamming his own back into the closed door. At that point, the AP moved patient 2 to the ground in a side lying hold. A total of seven staff were involved with the incident command security involving patient 2. It took approximately 9 minutes for staff to apply restraints.

During survey interviews with patient 1 and patient 2, both reported they felt safe, denied injuries, and did not have recollection of the incidents.

During an interview, facility leadership stated they reviewed the security video footage. Leadership stated during admission, patient 1 ran out of the intake area and into the courtyard. Patient 1 was posturing and acted aggressively toward staff. Leadership stated for safety of the staff and other patients in the courtyard the manual hold was appropriate. Leadership stated patient 2, threatened an assault walking with staff and the AP used a manual hold. Leadership stated security support staff are taught to not lift patients off the ground during the hold and

the AP did lift patient 2 off the ground. Leadership stated they spoke with AP, who stated he felt he need to lift patient 2 off the ground for a short time to get him onto the unit.

During an interview, the AP stated he receives training twice a year on the EASE Foundations program. The AP said with patient 1 he responded to an incident command call to the courtyard and received a cue from staff to initiate a manual hold. The AP stated during the incident with patient 2, after patient 2 postured, yelled, and raised his first to punch him in the face there was imminent risk of harm. The AP stated he used a manual hold on patient 2. The AP stated ideally patients should not be lifted off the ground during a manual hold, but sometimes there is a height difference with his height versus the patient that makes it difficult.

In conclusion, the Minnesota Department of Health determined abuse was inconclusive.

“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, neither was available.

Family/Responsible Party interviewed: Not applicable.

Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility retrained all staff on the EASE program and the proper way to use manual holds and conduct takedowns with patients.

Action taken by the Minnesota Department of Health:
The facility was issued a federal deficiency and/or a state correction order for noncompliance with licensing requirements. For a copy of the Statement of Deficiencies, please call 651-201-4890.

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
	00004	A. BUILDING: _____ B. WING _____	C 11/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANOKA-METRO REG TREATMENT CTR	3301 SEVENTH AVE NORTH ANOKA, MN 55303

(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 #H40022562M, and H40022527M, 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	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.	