Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: H40027844M
Compliance #: H40024305C

Date Concluded: March 8, 2024

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: 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) physically abused a patient when the AP used unapproved holds and techniques when manually restraining the patient.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was not substantiated. The AP provided protection to another staff member when the AP physically removed the patient away from the staff member the patient was physically attacking. The AP used a variety of physical holds and force to ensure the safety of all people present.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the patient. The investigation included review of the MDH complaint survey records, resident records, facility internal investigation, facility incident reports, personnel files, related facility policy and procedures, and video footage.

The patient resided in a psychiatric hospital. The patient's diagnoses included major depressive disorder with psychotic features. The patient's behavioral history included aggression and physical assault. The patient walked independently and resided in a low stimulation unit.

One day, a surveillance video indicated the patient, AP, and a security support staff member were playing basketball in the facility courtyard. When attempting to re-enter the facility, the security support staff member reached out to open the door of the facility. The patient then rushed the staff member from behind and struck the staff member multiple times on the back of his head and neck area. The AP immediately responded and physically pulled the patient away from the security support staff member. While doing so, the AP and patient tripped and fell to the ground. The AP returned to his feet. The patient began to get up and move towards the AP, the AP pushed the patient back to the ground. The AP and the security support staff then restrained the patient against a fence while other staff approached to assist.

The patient's hospital record indicated the patient had three previous physical attacks on the hospital staff prior to the incident under investigation.

The hospital incident report indicated two staff members obtained injuries during the incident. Subsequently, staff placed the patient in seclusion. While in seclusion, the patient refused to take medication and spit in the face of a nurse.

During investigative interviews, multiple staff members stated all staff receive training on verbal and physical de-escalation skills and techniques approved for use, including manual physical restraints. The staff stated the frequency for the need to use the techniques varies from multiple times a day to zero times a day. The staff stated they have received directive to protect themselves or others if they are in grave danger and the trained techniques are ineffective.

During investigative interviews, nursing supervisors stated the AP did not have any employment concerns or disciplines prior to the incident.

During the MDH complaint survey interview, the patient stated he felt safe at the facility and denied any injury occurring at the facility.

During an interview, the security support staff member stated he felt the training to protect oneself was not sufficient; that the training was more centered around protecting the patient. The staff member stated the AP responded appropriately given the level of danger they were in. The staff member stated the patient did not obtain any injuries or show any adverse effects after the incident.

The AP declined to participate in an interview.

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, conducted by survey.
Family/Responsible Party interviewed: No. Not available.
Alleged Perpetrator interviewed: No. Declined interview.

Action taken by facility:
The facility suspended the AP pending investigation and investigated the incident.

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
	00004	A. BUILDING: _____ B. WING _____	C 02/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANOKA METRO REGIONAL TREATMENT CENT	3301 7TH 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 #H40027844M, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557. No correction orders are issued.	6 000		