Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: H01062688M
Compliance #: H01061068C

Date Concluded: September 19, 2024

Name, Address, and County of Licensee Investigated:
Regions Hospital
640 Jackson Street
Saint Paul, MN 55101
Ramsey County

Facility Type: Hospital

Evaluator's Name: Willette Shafer, RN
Special Investigator

Finding: Inconclusive

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 the AP sprayed Repuls, a chemical deterrent, in the patient's eyes after verbal de-escalation techniques were unsuccessful to calm the patient.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was inconclusive. The AP sprayed the patient with Repuls after several failed attempts to de-escalate the patient who threatened harm against staff. There were six security officers present during the show of support including the AP's direct supervisor. The AP's supervisor and other security officers failed to intervene and redirect the AP from discharging the Repuls.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted law enforcement and the

patient's provider. The investigation included review of the resident's records, facility internal investigation, facility incident reports, personnel files, law enforcement report, and related facility's policies and procedures.

The patient admitted to the hospital's emergency department mental health unit. The patient's diagnoses included schizophrenia and alcohol withdrawal syndrome. The patient was extremely agitated and refused verbal redirection from staff. The patient was over six feet tall and over 300 pounds.

Per the internal investigation, the AP used a chemical deterrent to subdue the patient. The AP was involved in a previous incident with the patient where the patient was physically aggressive towards multiple security officers. During that event, the patient damaged property and was difficult to physically control. Due to the past incident and the size of the patient, the AP and other security officers believed the patient intended to cause great bodily harm based on direct threats made by the patient. Although, circumstances did give cause for the AP to fear great bodily harm, the patient had not attempted to harm anyone during the event. The hospital completed education on the use of weapons with all security officers.

Per the hospital's policies had conflicting information regarding the use of a chemical deterrent. The hospital's use of force policy indicated the use of force shall be reasonable to gain control of the person or situation to make the situation safe quickly and effectively. On the grid of when to use force, using a defensive spray can be utilized beginning with passive resistance leading into active resistance. The policy also indicated another officer has a duty to intervene when another officer or staff use excessive force or fail to follow the standard. However, the hospital's security officer use of weapons policy indicated a "weapon" includes chemical deterrents. Verbal threats of harm and potential harm were not adequate to justify use of a weapon.

Per the security video, the patient appeared agitated, and security directed the patient to sit in the restraint chair. The patient continued to stand in hallway, flailed hands while he spoke to staff. At least six security officers were present when the AP aimed the Repuls at the patient. The AP aimed the Repuls with arm extended at shoulder height at the patient for 25 seconds before the AP deployed the Repuls. Six security officers failed to intervene while the AP aimed the Repuls at the patient.

During an interview, the nurse said the patient became agitated after another patient was disruptive and loud in the hallway. She said multiple staff tried to de-escalate the patient, but he became verbally aggressive and postured towards staff. The patient failed to respond to verbal redirection. The patient was very large, and she was concerned staff were in danger. She said multiple security officers attempted to physically assist the patient to the restraint chair, but he became physically aggressive, so they stopped. She said one of the security officers sprayed the patient with Repuls, then several security officers assisted the patient to the restraint chair. The patient recovered quickly from the irritant.

During an interview, the security officer said he was unsuccessful during his attempt to de-escalate the patient. He said the patient was a large man and threatened to kill staff. He had never witnessed Repuls used on a patient in the past. He said he received education on Repuls before the incident and again after. Repuls should not be used to intervene during an incident of verbal threatening. The security officer said everyone saw the AP draw the Repuls and aim it at the patient. He denied he said anything to the AP before the AP activated the Repuls. After the Repuls was activated, they gained control of the patient and assisted him to the restraint chair.

During an interview, a supervisor said he was present during the incident. He said the patient was verbally aggressive and threatening. He said Repuls could only be used in a situation where substantial bodily harm was imminent. He said he felt threatened, but he was not concerned about substantial bodily harm. He had never seen Repuls used or aimed at a patient in the past. He was aware of the hospital's policies and the duty to intervene if the use of force was excessive. He denied that he or any other staff present during the incident intervened when the AP aimed the Repuls at the patient.

During an interview, the patient's provider said he was present during the incident. He said the patient escalated quickly and he was concerned someone would be seriously injured. He heard the AP warn the patient several times before he used the Repuls. He said he never heard anyone tell the AP not to use the Repuls. The patient recovered quickly from the irritant.

The AP failed to respond for an interview.

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

Inconclusive: Minnesota Statutes, section 626.5572, Subdivision 11.
"Inconclusive" means there is less than a preponderance of evidence to show that maltreatment did or 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;
(3) use of any aversive or deprivation procedure, unreasonable confinement, or involuntary seclusion, including the forced separation of the vulnerable adult from other persons against the will of the vulnerable adult or the legal representative of the vulnerable adult; and

Vulnerable Adult interviewed: No, unable to find reliable contact information.
Family/Responsible Party interviewed: No, medical record lacked family contacts.
Alleged Perpetrator interviewed: No, never responded to interview requests.

Action taken by facility:
The hospital completed an internal investigation. The hospital completed re-education with all security officers.

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
	00527	A. BUILDING: _____ B. WING _____	C 07/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIONS HOSPITAL	640 JACKSON STREET SAINT PAUL, MN 55101

(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 #H08064581M, and H01062688M in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557. No correction orders are issued.	6 000		