DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: H01064581M
Compliance #: H01063920C
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: 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 the patient when the AP twisted the patient's ankle while applying the leg restraint on the mechanical restraint chair.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was not substantiated. The AP assisted two security officers to manually restrain the patient. The patient was physically aggressive and difficult to gain control of. Neither security officers present witnessed the AP twist the patient's ankle. The AP used a manual hold he was trained to use. The patient was assessed after the incident and no injuries were noted.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of the patient's medical record, facility internal investigation, facility incident reports, personnel files, and the hospital's policies and procedures.

The patient admitted to the mental health unit. The patient's diagnoses included psychosis and mood disorder.

Per the hospital progress notes, the patient was paranoid, dangerous, and required seclusion and restraint for much of his hospital admission. When the incident occurred, the patient had been in seclusion for five days for extreme agitation with aggressive behaviors. He was pounding on windows and combative when staff administered medications. Patient was assisted to the restraint chair after he attempted to hit and kick security staff.

During an interview, a supervisor said he observed the incident on the live security camera. He said when the patient was assisted to the ground, the AP twisted the patient's ankle at an awkward angle. He said nursing staff and security officers completed different training on manual holds and therapeutic techniques, so he was unsure if the hold the AP appeared to use on video was an approved manual hold. He said the patient was physically aggressive during the manual hold. The AP had no disciplinary history involving similar events.

During an interview, a member of management said she completed the internal investigation. She said the AP used a therapeutic manual hold he was trained to use but the resident was physically aggressive and difficult to hold. The AP reported to her that he never tried to hurt or injure the patient. She said the AP had no similar incidents in the past and the AP was a long term, outstanding nurse who won several awards for his leadership.

During an interview, security officer-1 said he was present during the incident. The patient was physically aggressive and attempted to strike at staff. He and security officer-2 assisted the patient to the ground along with the AP. He said he and the other security officer were restraining the arms while the AP held the legs. He said he never saw how the AP held the patient as he was facing the other way. He said the patient spoke a different language, so he was unaware if the patient complained of pain.

During an interview, security officer-2 said he held the upper half of the patient's body during the manual hold and was unaware of how the AP held the patient's legs.

During an interview, the AP said the patient was physically aggressive during the incident. The patient was manually restrained on a mattress on his side. Two security officers held the patient's arms, but the patient continued to aggressively kick his legs. The AP tried to control the patient's leg by stabilizing his leg in the air. Due to the position of patient, there was nothing for the AP to stabilize the patient's leg against. The patient continued to kick his legs which made it difficult to stabilize his leg. The AP never intended to injure or inflict pain during the manual hold. Although the medical record lacked documentation of an assessment, the AP said an assessment was completed and no injuries were noted to the patient's legs.

Per the AP's training record, the AP completed annual restraint training one month prior to the incident.

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:
(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: No, declined interview.
Family/Responsible Party interviewed: No, MDH investigator spoke with the patient's family. The family had no knowledge of the incident.
Alleged Perpetrator interviewed: Yes.

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

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

Minnesota Department of Health

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		

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE