Incident Report and Internal Review

All incidents must be reported within 24 hours of the incident or within 24 hours of when the program became aware of the incident. A separate form must be completed for each person – do not use identifying information, such as names or initials, if the incident involved another person receiving services.

Date of incident: _____ Time of incident: _____ ▫ am / ▫ pm

Location of incident: _____

Person name: _____

Program Name: _____ License Number: _____

I. **Incident Type** (check all that apply):

☐ Death or serious Injury (Must also be reported using the forms from the Office of Ombudsman for Mental Health and Developmental Disabilities):

- Fractures;
- Dislocations;
- Evidence of internal injuries;
- Head injuries with loss of consciousness or potential for a closed head injury or concussion without loss of consciousness requiring a medical assessment by a health care professional, whether or not further medical attention was sought;
- Lacerations involving injuries to tendons or organs and those for which complications are present;
- Extensive second degree or third degree burns and other burns for which complications are present;
- Extensive second degree or third degree frostbite, and other frostbite for which complications are present;
- Irreversible mobility or avulsion of teeth;
- Injuries to the eyeball;
- Ingestion of foreign substances and objects that are harmful;
- Near drowning;
- Heat exhaustion or sunstroke;
- Attempted suicide; and
- All other injuries and incidents considered serious after an assessment by a health care professional, including but not limited to self-injurious behavior, a medication error requiring medical treatment, a suspected delay of medical treatment, a complication of a previous injury, or a complication of medical treatment for an injury.

☐ Any medical emergency, unexpected serious illness, or significant unexpected change in an illness or medical condition that requires the program to call 911, physician, advanced practice registered nurse, or physician assistant treatment, or hospitalization

☐ Any mental health crisis that requires the program to call 911 or a mental health crisis intervention team

An act or situation involving a person that requires the program to call 911, law enforcement, or the fire department

Unauthorized or unexplained absence from a program

Conduct by a person against another person that: is so severe, pervasive, or objectively offensive that it substantially interferes with a person's opportunities to participate in or receive service or support; places the person in actual and reasonable fear of harm; places the person in actual and reasonable fear of damage to property of the person; or substantially disrupts the orderly operation of the program

Any sexual activity between persons that involves force or coercion

Any emergency use of manual restraint (Also refer to Emergency Use of Manual Restraint Policy)

A report of alleged or suspected child or vulnerable adult maltreatment (Also refer to Maltreatment of Minors or Vulnerable Adults Reporting Policy)

II. **Description of incident:**

III. **Description of staff response to the incident:**

Applicable support plan addendum(s) were implemented for the person(s) involved.

Applicable program policies and procedures were implemented as written.

Staff person(s) who responded to the incident: _____

Name and signature of reporting staff _____ Date _____

IV. Persons Notified (within 24 hours of the incident)

Case manager: _____
Name Date Time

Legal representative or: _____
designated emergency contact Name Date Time

Other: _____
Name Date Time

Other: _____
Name Date Time

Other: _____
Name Date Time

Ombudsman**: _____
Date Time

DHS Licensing**: _____
or OHFC for ICF/DD Date Time

** Notified of death and serious injuries only

V. Internal Review of Incident

Items A to C are required for serious injuries, including deaths, emergency use of manual restraint, and alleged or suspected maltreatment. Items D and E are required for ALL incidents.

A. Were the related policies and procedures followed? Yes No

If no, explain.

B. Were the policies and procedures adequate? Yes No

If no, explain

C. Is there a need for additional staff training? Yes No

If yes, what training is needed, when will it be provided, and who will attend?

D. Is the incident similar to past events with the persons or the services involved? Yes No

If yes, identify the incident patterns.

E. Is there a need for corrective action by the program to protect the health and safety of the persons receiving services and to reduce future occurrences? Yes No

If yes, identify the corrective action plan designed to correct current lapses and prevent future lapses in performance by staff or the program. (Include applicable implementation dates, staff assigned to take the corrective action, and attach relevant documentation.)

For emergency use of manual restraint only: Is there a need to revise the person's service and support strategies? Yes No

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Name and signature of staff completing internal review Date

Emergency Report and Internal Review

Program Name: _____

Date of emergency: _____ Time of emergency: _____ ▫ am / ▫ pm

Location of emergency: _____

"Emergency" means any event that affects the ordinary daily operation of the program including, but not limited to, fires, severe weather, natural disasters, power failures, or other events that threaten the immediate health and safety of a person receiving services and that require calling 911, emergency evacuation, moving to an emergency shelter, or temporary closure or relocation of the program to another facility or service site for more than 24 hours.

This report must be completed within 24 hours of the emergency or within 24 hours of when the program became aware of the emergency.

This form is completed when an Event AND a Response are checked below.

I. **Emergency Type** (check all that apply):

Event:

Fire
Severe weather
Natural disaster
Power failure

Other event that threaten the immediate health and safety of a person

Response:

Calling 911
Emergency evacuation
Moving to an emergency shelter

Temporary closure or relocation of the program for more than 24 hours

II. Description of emergency:

NOTE: People receiving services do not need to be identified who were affected by or involved in the emergency. If the emergency resulted in an incident to a person, then an Incident Report and Internal Review form must be completed for that person.

III. Description of staff response to the emergency:

- ☐ Applicable support plan addendum(s) were implemented for person(s) involved.
- ☐ Applicable program policies and procedures were implemented as written.

Staff person(s) who responded to the emergency: _____

_____

Name and signature of reporting staff Date

IV. Internal Review

1. Was the emergency similar to past events with the persons, staff, or the services involved?

☐ Yes ☐ No If yes, identify the patterns, if any.

2. Based on the internal review, is there a need for corrective action by the program to protect the health and safety of the persons receiving services and to reduce future occurrences?

☐ Yes ☐ No If yes, identify the corrective action plan designed to correct current lapses and prevent future lapses in performance by staff or the program. [Attach relevant documentation. Insert name of staff person assigned to take corrective action and the specified time period in which corrective action will occur.]

_____

Name and signature of staff completing internal review Date

FGMI Notice of Service Termination Form

Notice of Service Termination

Date

Person/Legal Guardian
Address
City, State Zip

re: Service Termination
Name
DOB
PMI

Dear [the person receiving services or legal representative]:

This letter is notification of service termination for [name of person receiving services]. You are currently receiving _____ services funded by the following waiver program: __BI, __CAC, __CADI, __DD, __EW/AC.

The effective date of service termination is [date must be at least 30 days for basic support services and 60 days for intensive support services after the program has provided this written notice to the person, legal representative, and case manager].

The reason for the service termination:

____ The termination is necessary for your welfare and the license holder cannot meet your needs.

____ The safety of you, others in the program, or staff is endangered and positive support strategies were attempted and have not achieved and effectively maintained safety of you or others.

____ The health of you, others in the program, or staff would otherwise be endangered.

____ This license holder has not been paid for services provided to you.

____ This program or the license holder ceases to operate.

____ You have been terminated by your county social service agency from waiver eligibility.

Prior to giving this service termination notice, this program has at a minimum:

____ Consulted with your support team or expanded support team to identify and resolve issues leading up to the issuance of this termination notice.

____ Made a request to your case manager for intervention services or other professional consultation or intervention services to support you in this program.

FGMI Notice of Service Termination Form

This program has taken the following actions and/or measures to minimize or eliminate the need for proposed service termination:

The reason(s) why the actions and/or measures failed to prevent the proposed service termination:

You have the right to appeal this termination of services under Minnesota Statutes, section 256.045, subdivision 3, paragraph (a). See attached form – Request to Appeal a Service Termination.

You have the right to seek a temporary order preventing the termination of services according to procedures in Minnesota Statutes, section 256.045, subdivision 4a or 6, paragraph (c). See attached form – Request to Seek a Temporary Order Staying the Termination of Services.

During the service termination notice period, this program will

- work with your support team or expanded support team to develop reasonable alternatives to protect you and others and to support continuity of your care;
- provide information requested by you or your case manager; and
- maintain information about the service termination, including this notice, in your record.

Name/Title/Signature _____ Date _____

Name of provider, address, phone number _____

FGMI Notice of Service Termination Form

Date mailed:	Name	Title
		Person
		Legal Representative
	Name of Case Manager: County of Financial Responsibility: Case Manager Phone Number:	Case Manager
	Fax to 651-431-7406	DHS Commissioner (residential services only)

Attachments

REQUEST TO APPEAL A SERVICE TERMINATION

___ I wish to appeal the service termination notice that was provided to me.

I receive services from _____.
Their address is _____.
Their phone number is _____.
The date they provided me a service termination notice was _____.

I disagree with the action taken. I am appealing the proposed service termination because:

_____

_____

I wish to be contacted on further steps on the appeal process.

Contact Information	Name	Phone Number	Address
Person			
Legal Representative			

_____ _____
Person/Legal Representative Signature Date

SEND TO: Minnesota Department of Human Services
Appeals Office
PO Box 64941
St. Paul, MN 55164-0941

651-431-7523 (fax)

REQUEST TO SEEK A TEMPORARY ORDER STAYING THE TERMINATION OF SERVICES

___ I wish to seek a temporary order to prevent the termination of my services.

I receive services from _____.
Their address is _____.
Their phone number is _____.
The date they provided me a service termination notice was _____.

I disagree with the action taken. I am seeking a temporary order staying the termination of my services because:

_____

_____

Contact Information	Name	Phone Number	Address
Person			
Legal Representative			

_____ _____
Person/Legal Representative Signature Date

SEND TO: County social service agency that is financially responsible for your services

NOTICE OF TEMPORARY SERVICE SUSPENSION

Date [insert date of written notice]

Person/Legal Guardian
Address
City, State Zip

re: Temporary Service Suspension
Name
DOB
PMI

Dear [the person receiving services or legal representative]:

This letter is notification of temporary service suspension for [name of person receiving services]. You are currently receiving _____ services funded by the following waiver program: __BI, __CAC, __CADI, __DD, __EW/AC.

The effective date of the temporary service suspension is _____.

The reason for the temporary service suspension:

____ Your conduct posed an imminent risk of physical harm to yourself or others and positive support strategies have been implemented to resolve the issues leading to the temporary service suspension but have not been effective and additional positive support strategies would not achieve and maintain safety, or less restrictive measures would not resolve the issues leading to the suspension.

____ You have emergent medical issues that exceed this program's ability to meet your needs.

____ This program has not been paid for services.

Prior to giving this temporary service suspension notice, this program has at a minimum:

____ Consulted with your support team or expanded support team to identify and resolve issues leading up to the issuance of this notice of temporary service suspension.

____ Made a request to your case manager for intervention services or other professional consultation or intervention services to support you in this program.

FGMI Notice of Temporary Service Suspension

This program has taken the following actions to minimize or eliminate the need for temporary service suspension:

The reason(s) why the actions and/or measures failed to prevent the temporary service suspension:

During the temporary suspension period, this program must provide information requested by you or your case manager. This program will work with your support team or expanded support team to develop reasonable alternatives to protect you and other and to support continuity of care.

If, based on a review by your support team or expanded support team, that team determines you no longer pose an imminent risk of physical harm to yourself or others, you have the right to return to receiving services.

If, at the time of the service suspension or at any time during the suspension, you are receiving treatment related to the conduct that resulted in the service suspension, your support team or expanded support team must consider the recommendation of the licensed health professional, mental health professional, or other licensed professional involved in your care or treatment when determining whether you no longer poses an imminent risk of physical harm to yourself or others and can return to the program.

Name/Title/Signature _____ Date _____

Name of provider, address, phone number _____

Date mailed:	Name	Title
		Person
		Legal Representative
	Name of Case Manager: County of Financial Responsibility: Case Manager Phone Number:	Case Manager
	Fax to 651-431-7406	DHS Commissioner (residential services only)