MRCI

Support Team Meeting Summary

Person name: _____

Program name: _____

Date of team meeting: _____

This program must participate in service planning and support team meetings for the person following the stated timelines established in the person's coordinated service and support plan or as requested by the person or the person's legal representative, the support team, or the expanded support team. [245D.07, subd. 2 and 245D.071, subd. 5]. For a person receiving intensive support services, meetings must also occur within 30 days of a written request by the person, their legal representative, or the case manager at a minimum of once per year.

This form is used to document the discussion that occurred at the meeting. The discussion and documentation may be the basis for amending the coordinated service and support plan addendum.

Support Team Members Present:

Name	Signature	Title
		Person
		Legal Representative
		Case Manager

1. How has this program provided services in response to your identified needs, interests, preferences, and desired outcomes as specified in the ~~coordinated service and~~ support plan and the ~~coordinated service and~~ support plan addendum?

2. How has this program provided services to you in a manner that supports your preferences, daily needs, and activities and accomplishment of your personal goals and service outcomes?

3. How has this program provided services to you consistent with the principles of person-centered service planning and delivery that:
   a. Identifies and supports what is important *to you* as well as what is important *for you*, including your preferences for when, how, and by whom direct support service is provided to you?

   b. Uses that information to identify outcomes you desire?

   c. Respects your history, dignity, and cultural background?

Recommendations:

1.

2.

3.

MRCI

POLICY AND PROCEDURE ON ADMISSION

I. PURPOSE

The purpose of this policy is to establish procedures that ensure continuity of care during admission or service initiation including MRCI's admission criteria and processes.

II. POLICY

Services may be provided by MRCI as registered and licensed according to MN Statutes, chapter 245D and MN Statutes, chapter 245A. All services will be consistent with the person's service-related and protection-related rights identified in MN Statutes, section 245D.04. MRCI may provide services to persons with disabilities, including, but not limited to, developmental or intellectual disabilities, brain injury, mental illness, age-related impairments, or physical and medical conditions when MRCI is able to meet the person's needs.

Documentation from the admission/service initiation, assessments, and service planning processes related to MRCI's service provision for each person served and as stated within this policy will be maintained in the person's service recipient record.

III. PROCEDURE

Admission criteria

A. Certain criteria will be used by this company to determine whether MRCI is able to develop services to meet the needs of the person as specified in their *Support Plan*. In addition to registration and licensed ability, the criteria includes:
   1.
   2.
   3.
   4.

B. When a person and/or legal representative requests services from MRCI, a refusal to admit the person must be based upon an evaluation of the person's assessed needs and MRCI's lack of capacity to meet the needs of the person.

C. MRCI must not refuse to admit a person based solely on the type of residential services the person is receiving or solely on the person's:
   1. Severity of disability.
   2. Orthopedic or neurological handicaps.
   3. Sight or hearing impairments.
   4. Lack of communication skills.
   5. Physical disabilities.
   6. Toilet habits.
   7. Behavioral disorders.
   8. Past failures to make progress.

E. Documentation regarding the basis for the refusal will be completed using the *Admission Refusal Notice* and must be provided to the person and/or legal representative and case manager upon request. This documentation will be completed and maintained by the Designated Coordinator and/or Designated Manager or designee.

Admission process and requirements

A. In the event of an emergency service initiation, MRCI must ensure that staff training on individual service recipient needs occurs within 72 hours of the direct support staff first having unsupervised contact with the person served. MRCI must document the reason for the unplanned or emergency service initiation and maintain the documentation in the person's service recipient record.

B. Prior to or upon the initiation of services, the Designated Coordinator and/or Designated Manager will develop, document, and implement the *Individual Abuse Prevention Plan* according to MN Statutes, section 245A.65, subdivision 2.

C. The Designated Coordinator and/or Designated Manager will ensure that during the admission process the following will occur:
   1. Each person to be served and/or legal representative is provided with the written list of the *Rights of Persons Served* that identifies the service recipient's rights according to MN Statutes, section 245D.04, subdivisions 2 and 3.
      a. An explanation will be provided on the day of service initiation or within five (5) working days of service initiation and annually thereafter.
      b. Reasonable accommodations will be made, when necessary, to provide this information in other formats or languages to facilitate understanding of the rights by the person and/or legal representative.
   2. Orientation to MRCI's *Program Abuse Prevention Plan* will occur within 24 hours of service admission, or for those persons who would benefit more from a later orientation, the orientation may take place within 72 hours.
   3. An explanation of and provision of a copy of the *Policy and Procedure on Reporting and Reviewing of Maltreatment of Vulnerable Adults* will be provided to the person served and/or legal representative and case manager within 24 hours of admission, or for persons who would benefit more from a later orientation, the orientation may take place within 72 hours.
   4. An explanation of and provision of copies (may be provided within five [5] working days of service initiation) of the following policies and procedures to the person and/or legal representative and case manager:
      1. *Policy and Procedure on Grievances*
      2. *Policy and Procedure on Temporary Service Suspension*
      3. *Policy and Procedure on Service Termination*
      4. *Policy and Procedure on Data Privacy*
      5. *Policy and Procedure on Emergency Use of Manual Restraint*
      6. *Policy and Procedure on Reporting and Reviewing of Maltreatment of Minors*
   5. Written authorization is obtained by the person and/or legal representative for the following:
      a. *Authorization for Medication and Treatment Administration*
      b. *Agreement and Authorization for Injectable Medications*
      c. *Authorization to Act in an Emergency*
      d. *Standard Release of Information*
      e. *Specific Release of Information*
      f. *Funds and Property Authorization*
         i. This authorization may be obtained within five (5) working days of the service initiation meeting and annually thereafter. The case manager also provides written authorization for the *Funds and Property Authorization.*
      g. The *Admission Form and Data Sheet* is signed by the person and/or legal representative and includes the date of admission or readmission, identifying information, and contact information for members of the support team or expanded support team and others as identified by the person and/or legal representative.

E. Also during the admission meeting, the support team or expanded support team, and other people as identified by the person and/or legal representative will discuss:
   1. MRCI's responsibilities regarding health service needs and the procedures related to meeting those needs as assigned in the ~~*Coordinated Service and*~~ *Support Plan* and/or ~~*Coordinated Service and*~~ *Support Plan Addendum*.
   2. The desired frequency of progress reports and progress review meetings, at a minimum of annually.

3. The initial *Funds and Property Authorization* and the Designated Coordinator and/or Designated Manager will survey, document, and implement the preferences of the person served and/or legal representative and case manager for the frequency of receiving statements that itemizes receipt and disbursements of funds or other property. Changes will be documented and implemented when requested.

F. If a person's licensed health care professional or mental health professional has determined that a manual restraint would be medically or psychologically contraindicated, MRCI will not use a manual restraint to eliminate the immediate risk of harm and effectively achieve safety. This statement of whether or not a manual restraint would be medically or psychologically contraindicated will be completed as part of service initiation planning.

Admission process follow up and timelines

A. The Designated Coordinator and/or Designated Manager or designee will ensure that the person's other providers, medical and mental health care professionals, and vendors are notified of the change in address and phone number.

B. The Designated Coordinator and/or Designated Manager or designee will ensure that the person's service recipient record is assembled according to company standards.

C. Within 15 calendar days of service initiation, the Designated Coordinator and/or Designated Manager will complete a preliminary *Coordinated Service and Support Plan Addendum* that is based upon ~~*Coordinated Service and*~~ *Support Plan*. At this time, the person's name and date of admission will be added to the *Admission and Discharge Register* maintained by the Designated Coordinator and/or Designated Manager.

D. When a person served requires a *Positive Support Transition Plan* for the emergency use or planned use of restrictive interventions prohibited under MN Statutes, chapter 245D, and is admitted after January 1, 2014:
   1. The *Positive Support Transition Plan* must be developed and implemented within 30 calendar days of service initiation.
   2. No later than 11 months after the implementation date, the plan must be phased out.

E. Before the 45-day meeting, the Designated Coordinator and/or Designated Manager will complete the *Self-Management Assessment* regarding the person's ability to self-manage in health and medical needs, personal safety, and symptoms or behaviors. This assessment will be based on the person's status within the last 12 months at the time of service initiation.

F. Before providing 45 calendar days of service initiation or within 60 calendar days of service initiation, whichever is shorter, the support team or expanded support team and other people as identified by the person and/or legal representative must meet to assess and determine the following based on information obtained from the assessment, ~~*Coordinated Service and*~~ *Support Plan,* and person centered planning:
   1. The scope of services to be provided to support the person's daily needs and activities.
   2. Outcomes and necessary supports to accomplish the outcomes.
   3. The person's preferences for how services and supports are provided including how the provider will support the person to have control of the person's schedule.
   4. Whether the current service setting is the most integrated setting available and appropriate for the person.
   5. Opportunities to develop and maintain essential and life-enriching skills, abilities, strengths, interests, and preferences.
   6. Opportunities for community access, participation, and inclusion in preferred community activities.

7. Opportunities to develop and strengthen personal relationships with other persons of the person's choice in the community.
8. Opportunities to seek competitive employment and work at competitively paying jobs in the community.
9. How services for this person will be coordinated across 245D licensed providers and members of the support team or expanded support team to ensure continuity of care and coordination of services for the person.

G. Also, at the 45-day meeting (and annually thereafter), the person and/or legal representative, case manager, and other people as identified by the person and/or legal representative will discuss how technology might be used to meet the person's desired outcomes. The ~~*Coordinated Service and*~~ *Support Plan* and/or ~~*Coordinated Service and*~~ *Support Plan Addendum* will include a summary of this discussion. The summary will include a statement regarding any decision that is made regarding the use of technology and a description of any further research that needs to be completed before a decision regarding the use of technology can be made.

H. Within 10 working days of the 45-day meeting, the Designated Coordinator and/or Designated Manager will develop a service plan that documents outcomes and supports for the person based upon the assessments completed at the 45-day meeting.

I. Within 20 working days of 45-day meeting, the Designated Coordinator and/or Designated Manager will submit to and obtain dated signatures from the person and/or legal representative and case manager to document completion and approval of the assessment and ~~*Coordinated Service and*~~ *Support Plan Addendum.*
   1. If, within 10 working days of this submission, the legal representative or case manager has not signed and returned the assessments or has not proposed written modifications, the submission is deemed approved and the documents become effective and remain in effect until the legal representative or case manager submits a written request to revise the documents.

Policy reviewed and authorized by:

_____

Print name & title Signature

Date of last policy review: _____ Date of last policy revision: _____

Legal Authority: MS §§ 245D.11, subd. 4; 245D.04, subd.2,(4) to (7), and 3, (8)

AUTHORIZATION FOR MEDICATION AND TREATMENT ADMINISTRATION

Name: Date of birth:

If responsibility for medication and treatment administration has been assigned to this company in the ~~*Coordinated Service and*~~ *Support Plan* and/or ~~*Coordinated Service and*~~ *Support Plan Addendum*, will obtain written authorization from the person served and/or legal representative.

I authorize the company to administer the following:

☐ Routine prescribed medications	☐ Prescribed psychotropic medication
☐ Routine prescribed treatments	☐ Prescribed PRN psychotropic medication
☐ Standing Order Medications (as authorized by prescriber)	☐ Other, please specify:

Please describe any limitations, if any, to the above checked boxes:

I understand the following:

- I may refuse to authorize to administer medication or treatment and that the company will not administer the medication.
- This authorization will remain in effect unless withdrawn in writing and it may be withdrawn at any time.
- must notify the prescriber as expediently as possible if I refuse to authorize the administration of medication or treatment and any directives or orders given will be followed.
- A refusal to authorize the administration of a specific psychotropic medication is not grounds for service termination and does not constitute an emergency. A refusal to administer the psychotropic medication may not be overridden without a court order.
- This authorization will be obtained at service initiation before administering medications or treatments.
- This authorization will be re-obtained annually.

_____ _____

Person served and/or legal representative Date

MRCI

Policy and Procedure on Data Privacy

Program Name: _____

I. PURPOSE

The purpose of this policy is to establish guidelines that promote service recipient rights ensuring data privacy and record confidentiality of persons served.

II. POLICY

According to MN Statutes, section 245D.04, subdivision 3, persons served by the program have protection-related rights that include the rights to:

- Have personal, financial, service, health, and medical information kept private, and be advised of disclosure of this information by the company.
- Access records and recorded information about the person in accordance with applicable state and federal law, regulation, or rule.

Orientation to the person served and/or legal representative will be completed at service initiation and as needed thereafter. This orientation will include an explanation of this policy and their rights regarding data privacy. Upon explanation, the Designated Manager and/or Designated Coordinator will document that this notification occurred and that a copy of this policy was provided.

This company encourages data privacy in all areas of practice and will implement measures to ensure that data privacy is upheld according to MN Government Data Practices Act, section 13.46. The company will also follow guidelines for data privacy as set forth in the Health Insurance Portability and Accountability Act (HIPAA) to the extent the company performs a function or activity involving the use of protected health information and HIPAA's implementing regulations, Code of Federal Regulations, title 45, parts 160-164, and all applicable requirements. The CEO will exercise the responsibility and duties of the "responsible authority" for all program data, as defined in the Minnesota Data Practices, MN Statutes, chapter 13. Data privacy will hold to the standard of "minimum necessary" which entails limiting protected health information to the minimum necessary to accomplish the intended purpose of the use, disclosure, or request.

III. PROCEDURE

Access to records and recorded information and authorizations

A. The person served and/or legal representative have full access to their records and recorded information that is maintained, collected, stored, or disseminated by the company. Private data are records or recorded information that includes personal, financial, service, health, and medical information.

B. Access to private data in written or oral format is limited to authorized persons. The following company personnel may have immediate access to persons' private data only for the relevant and necessary purposes to carry out their duties as directed by the ~~*Coordinated Service and*~~ *Support Plan* and/or ~~*Coordinated Service and*~~ *Support Plan Addendum*:

1. Executive staff.
2. Administrative staff.
3. Financial staff.
4. Nursing staff including assigned or consulting nurses.
5. Management staff including the Designated Coordinator and/or Designated Manager.
6. Direct support staff.

C. The following entities also have access to persons' private data as authorized by applicable state or federal laws, regulations, or rules:
   1. Case manager.
   2. Child or adult foster care licensor, when services are also licensed as child or adult foster care.
   3. Minnesota Department of Human Services and/or Minnesota Department of Health.
   4. County of Financial Responsibility or the County of Residence's Social Services.
   5. The Ombudsman for Mental Health or Developmental Disabilities.
   6. US Department of Health and Human Services.
   7. Social Security Administration.
   8. State departments including Department of Employment and Economic Development (DEED), Department of Education, and Department of Revenue.
   9. County, state, or federal auditors.
   10. Adult or Child Protection units and investigators.
   11. Law enforcement personnel or attorneys related to an investigation.
   12. Various county or state agencies related to funding, support, or protection of the person.
   13. Other entities or individuals authorized by law.

D. The company will obtain authorization to release information of persons served when consultants, sub-contractors, or volunteers are working with the company to the extent necessary to carry out the necessary duties.

E. Other entities or individuals not previously listed who have obtained written authorization from the person served and/or legal representative have access to written and oral information as detailed within that authorization. This includes other licensed caregivers or health care providers as directed by the release of information.

F. Information will be disclosed to appropriate parties in connection with an emergency if knowledge of the information is necessary to protect the health or safety of the person served or other individuals or persons. The Designated Coordinator and/or Designated Manager will ensure the documentation of the following:
   1. The nature of the emergency.
   2. The type of information disclosed.
   3. To whom the information was disclosed.
   4. How the information was used to respond to the emergency.
   5. When and how the person served and/or legal representative was informed of the disclosed information.

G. All authorizations or written releases of information will be maintained in the person's service recipient record. In addition, all requests made to review data, have copies, or make alterations, as stated below, will be recorded in the person's record including:
   1. Date and time of the activity.
   2. Who accessed or reviewed the records.
   3. If any copies were requested and provided.

Request for records or recorded information to be altered or copies

A. The person served and/or legal representative has the right to request that their records or recorded information and documentation be altered and/or to request copies.

B. If the person served and/or legal representative objects to the accuracy of any information, staff will ask that they put their objections in writing with an explanation as to why the information is incorrect or incomplete.
   1. The Designated Coordinator and/or Designated Manager will submit the written objections to the CEO who will make a decision in regards to any possible changes.

2. A copy of the written objection will be retained in the person's service recipient record.
3. If the objection is determined to be valid and approval for correction is obtained, the Designated Coordinator and/or Designated Manager will correct the information and notify the person served and/or legal representative and provide a copy of the correction.
4. If no changes are made and distribution of the disputed information is required, the Designated Coordinator and/or Designated Manager will ensure that the objection accompanies the information as distributed, either orally or in writing.

C. If the person served and/or legal representative disagrees with the resolution of the issue, they will be encouraged to follow the procedures outlined in the *Policy and Procedure on Grievances.*

Security of information

A. A record of current services provided to each person served will be maintained on the premises of where the services are provided or coordinated. When the services are provided in a licensed facility, the records will be maintained at the facility; otherwise, records will be maintained at the company's program office. Files will not be removed from the program site without valid reasons and security of those files will be maintained at all times.

B. The Designated Coordinator and/or Designated Manager will ensure that all information for persons served are secure and protected from loss, tampering, or unauthorized disclosures. This includes information stored by computer for which a unique password and user identification is required.

C. No person served and/or legal representative, staff, or anyone else may permanently remove or destroy any portion of the person's record.

D. The company and its staff will not disclose personally identifiable information about any other person when making a report to each person and case manager unless the company has the consent of the person. This also includes the use of other person's information in another person's record.

E. Written and verbal exchanges of information regarding persons served are considered to be private and will be done in a manner that preserves confidentiality, protects their data privacy, and respects their dignity.

F. All staff will receive training at orientation and annually thereafter on this policy and their responsibilities related to complying with data privacy practices.

Policy reviewed and authorized by:

_____

Print name & title Signature

Date of last policy review: _____ Date of last policy revision: _____

MRCI

DESIGNATED COORDINATOR REVIEW

Name: Program site:

Date of review:

Name of the Designated Coordinator completing the review:

*If the responsibilities of the Designated Coordinator and the Designated Manager are fulfilled by the same person in the company, both this form and the *Designated Manager Review* form may be completed by that person. If the responsibilities of both positions are filled by different persons in the company, each position will complete the applicable review form.

The Designated Coordinator is responsible for the delivery and evaluation of services provided by the license holder including the provision of supervision, support, and evaluation of activities that include:

- Oversight of the license holder's responsibilities assigned in each person's ~~*Coordinated Service and*~~ *Support Plan* and ~~*Coordinated Service and*~~ *Support Plan Addendum*.
- Taking the action necessary to facilitate the accomplishment of the outcomes according to 245D.07.
- Instruction and assistance to staff implementing the ~~*Coordinated Service and*~~ *Support Plan* and service outcomes, including direct observation of service delivery sufficient to assess staff competency.
- Evaluation of the effectiveness of service delivery, methodologies, and progress on each person's outcomes based on the measurable and observable criteria for identifying when the desired outcome has been achieved according to 245D.07

Review area	Evaluation	Write correction action plan and recheck date, if necessary
The *Coordinated Service and Support Plan (CSSP)*	~~*Coordinated Service and*~~ *Support Plan* date: Is the ~~*Coordinated Service and*~~ *Support Plan* consistent with the ~~*Coordinated Service and*~~ *Support Plan Addendum*? ☐ Yes ☐ No If no, indicate what is not consistent: Are health needs being met as assigned in the ~~*CSSP or CSSP*~~ *Support Plan or Support Plan Addendum*? ☐ Yes ☐ No Is any staff training/qualifications determined necessary in addition ~~*to CSSP or CSSP*~~ *Support Plan or Support Plan Addendum* requirements? ☐ Yes ☐ No	

	If yes, indicate what training or qualifications are necessary: Service responsibilities assigned to the license holder are being met and staff are implementing the plan. ☐ Yes ☐ No If no, indicate what is not being met:	
~~*Coordinated Service and*~~ *Support Plan* ~~*(CSSP)*~~ *Addendum*	~~*Coordinated Service and*~~ *Support Plan Addendum* date: Information contained in the ~~*CSSP*~~ *Support Plan Addendum* is accurate in all required areas for the person served: ☐ Yes ☐ No If no, indicate what information needs to be corrected:	
Service Outcomes and Supports and *Behavioral Outcome*	Service outcomes are consistent with the ~~*Coordinated Service and*~~ *Support Plan Addendum*. ☐ Yes ☐ No Current outcome statements include measurable and observable criteria for outcome achievement. ☐ Yes ☐ No	
Direct observation of service delivery and staff implementation of service outcomes and supports	Service outcomes observed during this review: 1. 2. 3. Staff observed implementing the service outcomes: 1. 2. Note any concern with staff implementation of the service outcomes: Based upon this direct observation, staff are deemed to be competent to perform their job functions and service delivery. ☐ Yes ☐ No	
Progress towards accomplishment of service outcomes and progress reports and service plan review meetings	Data is being collected accurately for each service outcome to indicate level of progress. ☐ Yes ☐ No Is progress being made towards accomplishment of service outcomes? ☐ Yes ☐ No	

	Progress report contains information on the person's status and summary data, recommendations, and rationale for each service outcome. ☐ Yes ☐ No Date of most recent team meeting: Service plan review meetings frequency completed as specified in ~~*CSSP*~~ *Support Plan*. ☐ Yes ☐ No Frequency: *Progress Report and Recommendations* frequency completed as specified in ~~*CSSP*~~ *Support Plan*. ☐ Yes ☐ No Frequency:	
Assessments	The *Individual Abuse Prevention Plan* is current and accurately reflects the person's vulnerabilities. ☐ Yes ☐ No Date of assessment: *Program Abuse Prevention Plan* date: The *Self-Management Assessment* is current, descriptive of the person's overall strengths, functional skills and abilities, behaviors or symptoms, and accurately reflects the person's ability to self-manage. ☐ Yes ☐ No Date of assessment:	
Positive support strategies and person-centered principles: 9544.0030	Have positive support strategies and person-centered principles been incorporated in writing into the person's treatment, service or individual plans? ☐ Yes ☐ No If not, what is being done to address this: Was an evaluation done with the person regarding their positive support strategies and person-centered principles? ☐ Yes ☐ No *Refer to 9544.0030, subpart 2 for positive support strategies and their standards. Upon this evaluation, are changes needed to positive support strategies or to enhance person-centeredness for the person? ☐ Yes ☐ No If yes, what is being done to address this: Date of review (completed every 6 months):	

Service recipient record	All information and documentation related to service provision for this person is being maintained accurately and as directed by the *Policy and Procedure on Data Privacy*. ☐ Yes ☐ No All documentation has been filed according to the *Service Recipient Record Index.* ☐ Yes ☐ No	
Indicate any additional areas to be addressed through this review.		

POLICY AND PROCEDURE ON EMERGENCIES

I. PURPOSE

The purpose of this policy is to provide guidelines on preparing for, reporting, and responding to emergencies to ensure the safety and well-being of persons served.

II. POLICY

The company will be prepared to respond to emergencies as defined in MN Statutes, section 245D.02, subdivision 8, that occur while providing services, to protect the health and safety of and minimize risk of harm to the person(s) served. Staff will address all emergencies according to the specific procedure outlined in this policy and act immediately to ensure the safety of persons served. After the situation has been resolved and/or the person(s) involved are no longer in immediate danger, staff will complete the necessary documentation in order to comply with licensing requirements on reporting and to assist in developing preventative measures, if applicable. For incident response procedures, staff will refer to the *Policy and Procedure on Responding to and Reporting Incidents*.

All staff will be trained on this policy and the safe and appropriate response to and reporting of emergencies. Program sites will have contact information of a source of emergency medical care and transportation readily available for quick and easy access. In addition, a list of emergency phone numbers will be posted in a prominent location and emergency contact information for persons served at the facility including each person's representative, physician, and dentist.

III. PROCEDURE

Defining emergencies

A. Emergency is defined as any event that affects the ordinary daily operation of the program including, but not limited to:
   1. Fires.
   2. Severe weather.
   3. Natural disasters.
   4. Power failures.
   5. Emergency evacuation or moving to an emergency shelter.
   6. Temporary closure or relocation of the program to another facility or service site for more than 24 hours.
   7. Other events that threaten the immediate health and safety of persons served and that require calling "911."

Preparing for emergencies

A. To be prepared for emergencies, a staff person trained in first aid will be available on site in a day services facility, and when required in a person's ~~*Coordinated Service and*~~ *Support Plan* ~~*(CSSP)*~~and/or ~~*(CSSP)*~~ *Support Plan Addendum*, be able to provide cardiopulmonary resuscitation (CPR), whenever persons are present and staff are required to be at the site to provide direct services.

B. Each day services facility will have a first aid kit readily available for use by, and that meet the needs, of persons served and staff. The first aid kit will contain, at a minimum, bandages, sterile compresses, scissors, and ice bag or cold pack, an oral or surface thermometer, mild liquid soap, adhesive tape, and a first aid manual.

C. Day service facilities will have:
   1. A floor plan available that identifies the locations of:
      a. Fire extinguishers and audible or visual alarm systems
      b. Exits, primary and secondary evacuation routes, and accessible egress routes, if any
      c. An emergency shelter within the facility

2. A site plan that identifies:
   a. Designated assembly points outside the facility
   b. Locations of fire hydrants
   c. Routes of fire department access
3. An emergency escape plan for each person served.

D. Quarterly fire and severe weather drills will be conducted throughout the year on various days of the week and times of the day. Staff and persons served in the facility will not be notified prior to the drill, if possible, to ensure correct implementation of staff responsibilities for response. The manager or designee will be responsible for the initiation of the emergency drill and will record the date, day, and time of the drill in the emergency plan files.

E. As part of the emergency plan file kept at the facility site, the following information will be maintained:
1. The log of quarterly fire and severe weather drills.
2. The readily available emergency response plan.
3. Emergency contact information for persons served at the facility including each person's representative, physician, and dentist.
4. Information on the emergency shelter within the facility and the designated assembly points outside the facility.
5. Emergency phone numbers that are posted in a prominent location.

F. If persons served require the use of adaptive procedures or equipment to assist them with safe evacuation, staff will receive specific instruction on these procedures and equipment.

Responding to emergencies

A. Staff will call "911" based upon the emergency situation as provided in each individual response procedure as stated below.

B. **Fire**
1. Staff will respond immediately to all fire and smoke detector alarms or signs of fire by activating the alarms system.
2. All persons will be evacuated from the building by staff and assembled at the established designated assembly point outside the facility.
3. "911" will be immediately called from a neighbor's telephone or a cell phone in order to report the fire.
4. Staff will contain the area of the fire, if feasible, by closing doors. If it is possible to put out the fire with a fire extinguisher, staff will attempt to do so.
5. Staff will notify the manager or designee.
6. Persons served and individuals will not reenter the program site until the police or fire department issue instructions that the area is safe.
7. If the program site is not habitable and relocation to a designated safe area such as an emergency shelter is necessary, staff will follow the procedures in Letter E of this **Responding to emergencies** section.

C. **Severe weather conditions and natural disasters**
1. At the first sign of severe weather, including but not limited to high winds, heavy snow or rain, or extreme temperatures, staff will confirm the location and safety of all persons served.
2. Staff will listen to the radio or watch television for current weather conditions.
3. Upon hearing sirens or a take cover warning, staff will notify all persons that they need to seek shelter and will guide all persons to the designated safe area in the facility and will also bring a battery operated radio or television set, first aid kit, and flashlight.
4. If feasible, persons served but not scheduled for supervision will be called and warned.
5. Staff will assist all persons in staying in the safe area until an all clear is issued through the radio or by other means.

6. If injury or damage occurs, staff will notify the manager or designee and follow directions given.
7. If relocation to a designated safe area such as an emergency shelter is necessary, staff will follow the procedures in Letter E of this **Responding to emergencies** section.

D. **Power failure (electricity outage or gas leak)**
1. During a power failure, all staff will remain with persons served. If persons are not in the immediate area at the program, staff will locate them and bring them to the central program area.
2. The power company will be contacted by cell phone to determine estimated length of the power outage. If estimated to last less than two hours, the manager or designee will be contacted to determine what actions will be taken. If the power outage is to last more than two hours, staff will transport the persons to a safe area or location as previously established by the manager.
3. If gas is smelled or a gas leak is suspected, staff will evacuate persons to the established designated assembly point outside the facility.
4. The gas company will be immediately notified and instructions followed.
5. No one will be permitted to use lighters, matches, or any open flame during this time. All electrical and battery-operated appliances and machinery will be turned off until the all clear has been provided.
7. The manager or designee will be notified of the gas leak. This call will be made by staff from the safe area using a cell phone or from a neighbor's phone.
8. If relocation to a designated safe area such as an emergency shelter is necessary, staff will follow the procedures in Letter E of this **Responding to emergencies** section.

E. **Emergency evacuation, moving to an emergency shelter, and temporary closure or relocation of the program to another facility or service site for more than 24 hours**
1. Staff will ensure that everyone leaves the building and will assist all persons in gathering at the designated assembly point outside the facility.
2. Staff will immediately notify the manager or designee of the conditions that may require emergency evacuation, moving to an emergency shelter, temporary closure, or the relocation of program to another site.
3. The manager or designee will coordinate relocation of services in a way that promotes continuity of care of persons served.
4. The manager or designee will coordinate and assist staff as necessary in transporting persons to the designated location.
5. If access to the program site is permitted, staff will transfer persons' program files, clothing, necessary personal belongings, current medications, and medication administration records to the designated location.
6. The manager will notify the legal representative or designated emergency contact, and case manager, and other licensed caregiver (if applicable) of the new location of the program if necessary.

F. **Other events that threaten the immediate health and safety of persons served and that require calling "911"**
1. Pandemic event: Upon request, staff will cooperate with state and local government disaster planning agencies working to prepare for or react to emergencies presented by a pandemic outbreak.
2. Bomb threat
   a. Upon receiving a bomb threat, staff at the program site should pull the fire alarm, if available.
   b. Staff will ensure that everyone leaves the building and assembles at the designated assembly point outside the facility.
   c. Staff will immediately call "911" from a neighbor's telephone or a cell phone.
   d. Staff and persons will remain outside the building until further instructions are received from the police or fire department.
   e. If unable to re-occupy the building, staff will follow the procedures in Letter E of this **Responding to emergencies** section.
3. Repeated and unwanted or threatening phone calls

a. Upon receiving repeated and unwanted or threatening phone calls, staff will hang up the phone immediately or encourage the person served to hang up the phone.
b. Staff will lock all doors and windows.
c. Staff will monitor the frequency of disruptive phone calls, informing the manager when the calls continue to a point where the safety of persons served is in question or when the calls are personally threatening or environmentally threatening to a program site or property.
d. Staff will call "911" if at any point they feel threatened.
e. The manager will determine when and if the telephone number will be changed due to the harassing or threatening telephone calls.

Reporting emergencies

A. Staff will immediately notify the manager that an incident or emergency has occurred and follow direction issued to them and will document the incident or emergency on an *Incident and Emergency Report* any related program or health documentation. Each *Incident and Emergency Report* will contain the required information as stated in the *Policy and Procedure on Reviewing Incidents and Emergencies.*

B. If an incident resulted from the emergency situation, the manager will maintain information about and report incidents to the legal representative or designated emergency contact and case manager within 24 hours of an incident occurring while services are being provided, within 24 hours of discovery or receipt of information that an incident occurred, unless the company has reason to know that the incident has already been reported, or as otherwise directed in the person's ~~*CSSP*~~ *Support Plan* and/or ~~*CSSP*~~ *Support Plan Addendum.*

C. When the incident or emergency involves more than person served, the company and staff will not disclose personally identifiable information about any other person served when making the report to each person and/or legal representative and case manager unless the company has the consent of the person and/or legal representative.

D. If a serious injury or death were to occur as a result of the emergency situation, staff will follow the response and reporting procedures as stated in the *Policy and Procedures on Responding to and Reporting Incidents* and, if needed, the *Policy and Procedure on Death of a Person Served.*

MRCI

POLICY AND PROCEDURE ON EMERGENCY USE OF MANUAL RESTRAINT-ALLOWED

I. PURPOSE

The purpose of this policy is to promote service recipient rights and protect the health and safety of persons served during the emergency use of manual restraint (EUMR). This policy will also promote appropriate and safe interventions needed when addressing behavioral situations.

II. POLICY

It is the policy of this company to ensure the correct use of emergency use of manual restraint, to provide intense training and monitoring of direct support staff, and to ensure regulations regarding the emergency use of manual restraint are followed. According to MN Statutes, section 245D.02, subdivision 8a, emergency use of manual restraint is defined as "using a manual restraint when a person poses an imminent risk of physical harm to self or others and is the least restrictive intervention that would achieve safety. Property damage, verbal aggression, or a person's refusal to receive or participate in treatment or programming on their own do not constitute an emergency."

III. PROCEDURE

Positive support strategies

A. MRCI will attempt to de-escalate a person's behavior before it poses an imminent risk of physical harm to self or others. Some of the following procedures could be used to de-escalate the situation and are options that could be implemented by staff. This is not a fully inclusive list of options that could include:

1. A calm discussion between the person served and direct support staff regarding the situation, the person's feelings, their responses, and alternative methods to handling the situation, etc.
2. A staff suggesting or recommending that the person participate in an activity they enjoy as a means to self-calm.
3. A staff to suggest or remind that the person served has options that they may choose to spend time alone, when safety permits, as a means to self-calm.
4. The individualized strategies that have been written into the person's *Support Plan* and/or *Support Plan Addendum*[1], or *Positive Support Transition Plan*.
5. The implementation of instructional techniques and intervention procedures that are listed as **"Permitted actions and procedures"** as defined in Letter B of this **Positive support strategies** section.
6. A combination of any of the above.

B. **Permitted actions and procedures** include the use of instructional techniques and intervention procedures used on an intermittent or continuous basis. If used on a continuous basis, it must be addressed in the person's *Support Plan Addendum*. These actions include:

1. Physical contact or instructional techniques that are the least restrictive alternative possible to meet the needs of the person and may be used to:
   a. Calm or comfort a person by holding that person with no resistance from that person.
   b. Protect a person known to be at risk or injury due to frequent falls as a result of a medical condition.
   c. Facilitate the person's completion of a task or response when the person does not resist or the person's resistance is minimal in intensity or duration.
   d. Block or redirect a person's limbs or body without holding the person or limiting the person's movement to interrupt the person's behavior that may result in injury to self or others with less than 60 seconds of physical contact by staff.
   e. Redirect a person's behavior when the behavior does not pose a serious threat to the person or others and the behavior is effectively redirected with less than 60 seconds of physical contact by staff.

1 Support plan previously known as Coordinated Services and Support Plan and/or Coordinated Services and Support Plan Addendum

2. Restraint may be used as an intervention procedure to:
   a. Allow a licensed health care professional to safely conduct a medical examination or to provide medical treatment ordered by a licensed health care professional.
   b. Assist in the safe evacuation or redirection of a person in the event of an emergency and the person is at imminent risk of harm.
   c. Position a person with physical disabilities in a manner specified in their *Support Plan Addendum.* Any use of manual restraint allowed in this paragraph must comply with the restrictions stated in the section of this policy **Restrictive Intervention.**
3. Use of adaptive aids or equipment, orthotic devices, or other medical equipment ordered by a licensed health professional to treat a diagnosed medical condition do not in and of themselves constitute the use of mechanical restraint.
4. Positive verbal correction that is specifically focused on the behavior being addressed.
5. Temporary withholding or removal of objects being used to hurt self or others.

Prohibited Procedures

MRCI and its staff are prohibited from using the following:

A. Chemical restraints
B. Mechanical restraints
C. Manual restraint
D. Time out
E. Seclusion
F. Any other aversive or deprivation procedures
G. As a substitute for adequate staffing
H. For a behavioral or therapeutic program to reduce or eliminate behavior
I. Punishment
J. For staff convenience
K. Prone restraint, metal handcuffs, or leg hobbles
L. Faradic shock
M. Speaking to a person in a manner that ridicules, demeans, threatens, or is abusive
N. Physical intimidation or a show of force
O. Containing, restricting, isolating, secluding, or otherwise removing a person from normal activities when it is medically contraindicated or without monitoring the person served
P. Denying or restricting a person's access to equipment and devices such as walkers, wheelchairs, hearing aids, and communication boards that facilitate the person's functioning. When the temporary removal of the equipment or device is necessary to prevent injury to the person or others or serious damage to the equipment or device, the equipment or device must be returned to the person as soon as imminent risk of injury or serious damage has passed.
Q. Painful techniques, including intentional infliction of pain or injury, intentional infliction of fear of pain or injury, dehumanization, and degradation
R. Hyperextending or twisting a person's body parts
S. Tripping or pushing a person
T. Requiring a person to assume and maintain a specified physical position or posture
U. Forced exercise
V. Totally or partially restricting a person's senses
W. Presenting intense sounds, lights, or other sensory stimuli
X. Noxious smell, taste, substance, or spray, including water mist
Y. Depriving a person of or restricting access to normal goods and services, or requiring a person to earn normal goods and services
Z. Token reinforcement programs or level programs that include a response cost or negative punishment component
AA. Using a person receiving services to discipline another person receiving services
BB. Using an action or procedure which is medically or psychologically contraindicated
CC. Using an action or procedure that might restrict or obstruct a person's airway or impair breathing,

including techniques whereby individuals use their hands or body to place pressure on a person's head, neck, back, chest, abdomen, or joints

DD. Interfering with a person's legal rights, except as allowed by MN Statutes, section 245D.04, subdivision 3, paragraph (c).

Restrictive Intervention:

A restrictive intervention means prohibited procedures identified in MN Statutes, section 245D.06, subdivision 5; prohibited procedures identified in MN Rules, part 9544.006; and the emergency use of manual restraint.

A restricted procedure must not:

A. Be implemented with a child in a manner that constitutes sexual abuse, neglect, physical abuse, or mental injury as defined in MN Statutes, chapter 260E.
B. Be implemented with an adult in a manner that constitutes abuse or neglect as defined in MN Statutes, section 626.5572, subdivisions 2 or 17.
C. Be implemented in a manner that violates a person's rights identified in MN Statutes, section 245D.04.
D. Restrict a person's normal access to a nutritious diet, drinking water, adequate ventilation, necessary medical care, ordinary hygiene facilities, normal sleeping conditions, or necessary clothing, or to any protection required by state licensing standards and federal regulations governing the program.
E. Deny the person visitation or ordinary contact with legal counsel, a legal representative, or next of kin.
F. Be used as a substitute for adequate staffing, for the convenience of staff, as punishment, or as a consequence if the person refuses to participate in the treatment of services provided by MRCI.
G. Use prone restraint (that places a person in a face-down position).
H. Apply back or chest pressure while a person is in the prone or supine (face-up) position.
I. Be implemented in a manner that is contraindicated for any of the person's known medical or psychological limitations.

Positive Support Transition Plans **(PSTP)**

MRCI must and will develop a *Positive Support Transition Plan* on forms provided by the Department of Human Services and in the manner directed for a person served who requires intervention in order to maintain safety when it is known that the person's behavior poses an immediate risk of physical harm to self or others. A PSTP must be developed in accordance with MN Statutes, section 245D.06, subdivision 8 and MN Rules, part 9544.0070 for a person who has been subjected to three (3) incidents of EUMR within 90 days or four (4) incidents of EUMR within 180 days. This *Positive Support Transition Plan* will phase out any existing plans for the emergency use or programmatic use of restrictive interventions prohibited under MN Statutes, Chapter 245D and MN Rules, Chapter 9544.

Emergency use of manual restraint (EUMR)

A. If the positive support strategies were not effective in de-escalating or eliminating the person's behavior, emergency use of manual restraint may be necessary. To use emergency use of manual restraint, the following conditions must be met:
    1. Immediate intervention must be needed to protect the person or others from imminent risk of physical harm.
    2. The type of manual restraint used must be the least restrictive intervention to eliminate the immediate risk of harm and effectively achieve safety.
    3. The manual restraint must end when the threat of harm ends.

B. The following conditions, on their own, are not conditions for emergency use of manual restraint:
    1. The person is engaging in property destruction that does not cause imminent risk of physical harm.
    2. The person is engaging in verbal aggression with staff or others.

3. A person's refusal to receive or participate in treatment of programming.

C. **The company allows certain types of manual restraints which may be used by staff on an emergency basis**. **Detailed instructions on the safe and correct implementation of these allowed manual restraint procedures are included at the end of this policy**. These allowed manual restraints include the following:
   1. Physical escort/walking: Stages 1 and 2
   2. Arm restraint/one staff person standing: 1 arm and 2 arm
   3. Arm restraint/one staff person sitting: 1 arm and 2 arm

D. If a person's licensed health care professional or mental health professional has determined that a manual restraint would be medically or psychologically contraindicated, MRCI will not use a manual restraint to eliminate the immediate risk of harm and effectively achieve safety. This statement of whether or not a manual restraint would be medically or psychologically contraindicated will be completed as part of service initiation planning.

Monitoring of emergency use of manual restraint

A. Each single incident of emergency use of manual restraint must be monitored and reported separately. For this understanding, an incident of emergency use of manual restraint is a single incident when the following conditions have been met:
   1. After implementing the manual restraint, staff attempt to release the person at the moment staff believe the person's conduct no longer poses an imminent risk of physical harm to self or others and less restrictive strategies can be implemented to maintain safety.
   2. Upon the attempt to release the restraint, the person's behavior immediately re-escalates and staff must immediately re-implement the restraint in order to maintain safety.

B. During an emergency use of manual restraint, MRCI will monitor a person's health and safety. Staff monitoring the manual restraint procedure will not be the staff implementing the procedure, when possible. A monitoring form will be completed by the staff person for each incident of emergency use of manual restraint to ensure:
   1. Only manual restraints allowed according to this policy are implemented.
   2. Manual restraints that have been determined to be contraindicated for a person are not implemented with that person.
   3. Allowed manual restraints are implemented only by staff trained in their use.
   4. The restraint is being implemented properly as required.
   5. The mental, physical, and emotional condition of the person who is being manually restrained is being assessed and intervention is provided when necessary to maintain the person's health and safety and prevent injury to the person, staff involved, or others involved.

Reporting of emergency use of manual restraint

A. Reporting of the incident of emergency use of manual restraint will be completed according to the following process and will contain all required information per MN Statutes, sections 245D.06, subdivision 1 and 245D.061, subdivision 5.

B. Within 24 hours of the emergency use of manual restraint, MRCI will make a verbal report regarding the incident to the legal representative or designated emergency contact and case manager. If other persons served were involved in the incident, MRCI will not disclose any personally identifiable information about any other person when making the report unless MRCI has the consent of the person.

C. Within three (3) calendar days of the emergency use of manual restraint, the staff who implemented the emergency use of manual restraint will report, in writing, to the Designated Coordinator and/or Designated Manager the following information:

1. The staff and person(s) served who were involved in the incident leading up to the emergency use of manual restraint.
2. A description of the physical and social environment, including who was present before and during the incident leading up to the emergency use of manual restraint.
3. A description of what less restrictive alternative measures were attempted to de-escalate the incident and maintain safety before the manual restraint was implemented. This description must identify the when, how, and how long the alternative measures were attempted before the manual restraint was implemented.
4. A description of the mental, physical, and emotional condition of the person who was restrained, and other persons involved in the incident leading up to, during, and following the manual restraint.
5. Whether there was any injury to the person who was restrained or other persons involved, including staff, before or as a result of the manual restraint use.
6. Whether there was a debriefing with the staff, and, if not contraindicated, with the person who was restrained and other persons who were involved in or who witnessed the restraint, following the incident. The outcome of the debriefing will be clearly documented and if the debriefing could not occur at the time of the incident, the report will identify whether a debriefing is planned in the future.

D. Within five (5) working days of the emergency use of manual restraint, the Designated Manager will complete and document an internal review of each report of emergency use of manual restraint. The internal review will include an evaluation of whether:
   1. The person's served service and support strategies developed according to MN Statutes, sections 245D.07 and 245D.071 need to be revised.
   2. Related policies and procedures were followed.
   3. The policies and procedures were adequate.
   4. There is a need for additional staff training.
   5. The reported event is similar to past events with the persons, staff, or the services involved.
   6. There is a need for corrective action by MRCI to protect the health and safety of the person(s) served.

E. Based upon the results of the internal review, MRCI will develop, document, and implement a corrective action plan for the program designed to correct current lapses and prevent future lapses in performance by the individuals or MRCI, if any. The Designated Manager will ensure that the corrective action plan, if any, must be implemented within 30 days of the internal review being completed.

F. Within five (5) working days after the completion of the internal review, the Designated Coordinator and/or Designated Manager will consult with the person's expanded support team following the emergency use of manual restraint. The purpose of this consultation is to:
   1. Discuss the incident and to define the antecedent or event that gave rise to the behavior resulting in the manual restraint and identify the perceived function the behavior served.
   2. Determine whether the person's served *Support Plan Addendum* needs to be revised to positively and effectively help the person maintain stability and to reduce or eliminate future occurrences requiring emergency use of manual restraint.

G. Within five (5) working dates of the expanded support team review, the Designated Coordinator and/or Designated Manager will submit, using the DHS online *Behavioral Intervention Reporting Form* (DHS-5148-ENG-1), the following information to the Department of Human Services and the Office of the Ombudsman for Mental Health and Developmental Disabilities:
   1. The report of the emergency use of manual restraint.
   2. The internal review and corrective action plan, if any.
   3. The written summary of the expanded support team's discussion and decision.

H. The following written information will be maintained in the person's service recipient record:
   1. The report of an emergency use of manual restraint incident that includes:
      a. Reporting requirements by the staff who implemented the restraint
      b. The internal review of emergency use of manual restraint and the corrective action plan, with information about implementation of correction within 30 days, if any
      c. The written summary of the expanded support team's discussion and decision
      d. The notifications to the expanded support team, the Department of Human Services, and the MN Office of the Ombudsman for Mental Health and Developmental Disabilities
   2. The PDF version of the completed and submitted DHS online *Behavioral Intervention Reporting Form* (DHS-5148-ENG-1). An email of this PDF version of the *Behavioral Intervention Reporting Form* will be sent to the MN-ITS mailbox assigned to the license holder.

Staff training requirements

A. MRCI recognizes the importance of having qualified and knowledgeable staff that are competently trained to uphold the rights of persons served and to protect persons' health and safety. All staff will receive orientation and annual training according to MN Statutes, section 245D.09, subdivisions 4, 4a, and 5. Orientation training will occur within the first 60 days of hire and annual training will occur within a period of 12 months.

B. Within 60 calendar days of hire, MRCI provides orientation on:
   1. The safe and correct use of manual restraint on an emergency basis according to the requirements in section 245D.061 or successor provisions, and what constitutes the use of restraints, time out, and seclusion, including chemical restraint; and
   2. Staff responsibilities related to prohibited procedures under section 245D.06, subdivision 5, MN Rules, part 9544.0060, or successor provisions, why such procedures are not effective for reducing or eliminating symptoms or undesired behavior, and why such procedures are not safe.

C. Before staff may implement an emergency use of manual restraint, and in addition to the training on this policy and procedure and the orientation and annual training requirements, staff must receive training on emergency use of manual restraints that incorporates the following topics:
   1. Alternatives to manual restraint procedures including techniques to identify events and environmental factors that may escalate conduct that poses an imminent risk of physical harm to self or others.
   2. De-escalation methods, positive support strategies, and how to avoid power struggles
   3. Simulated experiences of administering and receiving manual restraint procedures allowed by MRCI on an emergency basis
   4. How to properly identify thresholds for implementing and ceasing restrictive procedures
   5. How to recognize, monitor, and respond to the person's physical signs of distress including positional asphyxia
   6. The physiological and psychological impact on the person and the staff when restrictive procedures are used
   7. The communicative intent of behaviors
   8. Relationship building.

D. For staff that are responsible to develop, implement, monitor, supervise, or evaluate positive support strategies, *Positive Support Transition Plans*, or *Emergency Use of Manual Restraint*, the staff must complete a minimum of eight (8) hours of core training from qualified individuals prior to assuming these responsibilities. Core training must include the following:
   1. De-escalation techniques and their value
   2. Principles of person-centered service planning and delivery and how they apply to direct support services provided by staff

3. Principles of positive support strategies such as positive behavior supports, the relationship between staff interactions with the person and the person's behavior, and the relationship between the person's environment and the person's behavior
4. What constitutes the use of restraint, including chemical restraint, time out, and seclusion
5. The safe and correct use of manual restraint on an emergency basis, according to MN Statutes, section 245D.061
6. Staff responsibilities related to prohibited procedures under MN Statutes, section 245D.06, subdivision 5; why the procedures are not effective for reducing or eliminating symptoms or interfering behavior; and why the procedures are not safe
7. Staff responsibilities related to restricted and permitted actions and procedure according to MN Statutes, section 245D.06, subdivisions 6 and 7
8. Situations in which staff must contact 911 services in response to an imminent risk of harm to the person or others
9. Procedures and forms staff must use to monitor and report use of restrictive interventions that are part of a *Positive Support Transition Plan*
10. Procedures and requirements for notifying members of the person's expanded support team after the use of a restrictive intervention with the person
11. Understanding of the person as a unique individual and how to implement treatment plans and responsibilities assigned to the license holder
12. Cultural competence
13. Personal staff accountability and staff self-care after emergencies.

E. Staff who develop positive support strategies, license holders, executives, managers, and owners in non-clinical roles, must complete a minimum of four (4) hours of additional training. Function-specific training must be completed on the following:
   1. Functional behavior assessment
   2. How to apply person-centered planning
   3. How to design and use data systems to measure effectiveness of care
   4. Supervision, including how to train, coach, and evaluate staff and encourage effective communication with the person and the person's support team.

F. License holders, executives, managers, and owners in non-clinical roles must complete a minimum of two (2) hours of additional training. Function-specific training must be completed on the following:
   1. How to include staff in organizational decisions
   2. Management of the organization based upon person-centered thinking and practices and how to address person-centered thinking and practices in the organization
   3. Evaluation of organizational training as it applies to the measurement of behavior change and improved outcomes for persons receiving services.

G. Annually, staff must complete four (4) hours of refresher training covering each of the training topics listed in items D, E, and F above.

H. For each staff, the license holder must document, in the personnel record, completion of core training, function-specific training, and competency testing or assessment. Documentation must include the following:
   1. Date of training
   2. Testing or assessment completion
   3. Number of training hours per subject area
   4. Name and qualifications of the trainer or instructor.

I. The license holder must verify and maintain evidence of staff qualifications in the personnel record. The documentation must include the following:
   1. Education and experience qualifications relevant to the staff's scope of practice, responsibilities

assigned to the staff, and the needs of the general population of persons served by the program; and

2. Professional licensure, registration, or certification, when applicable.

IV. DETAILED INSTRUCTIONS ON ALLOWED MANUAL RESTRAINT PROCEDURES

If an emergency use of manual restraint is needed, staff will attempt to verbally calm the person down throughout the implemented procedure(s), unless to do so would escalate the person's behavior. The least restrictive manual restraint will be used to effectively handle the situation.

Physical escort/walking

If a person served has escalating behaviors and it is necessary to move the person, staff may follow stages 1 and 2 of physical escort/walking.

Stage 1: A staff person will walk by the side of the person while remaining slightly behind the person. Staff will place their hand that is closest to the person, on the person's forearm, just below the elbow while applying firm, but gentle pressure. While walking with the person, staff will remain near to the person so that the placement of the hand on the person's forearm is effective.

Stage 2: If stage 1 is not effective, staff may use both of their hands to move the person while walking. Staff will move their hand currently on the person's forearm to the person's small of their back and apply firm, but gentle pressure. Staff's other arm, that is farthest away from the person, will reach across and be placed on the person's forearm, below the elbow~~, on their forearm~~, while applying firm, but gentle pressure. In this position, staff will remain near to the person while walking with them to another area.

Arm restraint/one staff person standing and sitting

If a person served has escalating behaviors that can be managed through the use of a one arm restraint, staff will attempt to do so prior to using the two arm restraint. A standing restraint will be attempted first; however, if the person needs to sit, staff may use the arm restraint/one staff person sitting procedure.

Arm restraint/one staff person standing – 1 arm: Staff may use physical escort/walking, stage 2 to move into the 1 arm restraint/staff person standing or it may be used separately. Staff will direct one arm of the person served forward to cross in front of the person's body by applying slight pressure above or below their elbow. The same side arm will be used by staff and the person (i.e. staff's right arm will direct the right arm of the person forward). With their other arm, farthest away from the person, staff will lightly grip the person's crossed arm, slightly above the wrist, holding the arm in a crossed position. Staff will then slide their free arm between the person's arm and their waist, to grip the person's forearm. Staff will ensure that their palms are facing down.

Arm restraint/one staff person standing – 2 arm: Staff will direct one arm of the person served forward to cross in front of the person's body by applying slight pressure above or below their elbow. The same side arm will be used by staff and the person (i.e. staff's right arm will direct the right arm of the person forward). With their other arm, farthest away from the person, staff will lightly grip the person's crossed arm, slightly above the wrist, holding the arm in a crossed position. Staff will then slide their free arm between the person's arm and their waist, to grip the person's forearm. Staff will ensure that their palms are facing down. If the person continued to escalate in behaviors and it is necessary to restrain both of the person's arms, staff will release their arm that is griping the person's arm above the wrist. Staff will quickly bring their arm up and around to "pin" the person's free arm against their side. Staff will then re-grip the arm above the wrist that is crossed in front of the person so that one arm is crossed in front of the person and the other pressed against the person's side.

Arm restraint/one staff person sitting – 1 arm and 2 arm: Using the procedures as stated above in the

arm restraint/one staff person standing – 1 arm and 2 arm, staff may transition from a standing to a sitting position if necessary. While restraining the person's arm(s), staff will verbally notify the person of what they are doing and will slowly back up and lower the person to the floor. Staff may be in a sitting or kneeling position behind the person. Should the person attempt to hit staff with their head or aggressively rock back and forth, staff will pull slightly back while maintaining their restraint. If possible, staff will brace their shoulder against the person's shoulder or duck their head to avoid being hit.

Policy reviewed and authorized by:

_____

Print name & title Signature

Date of last policy review: _____ Date of last policy revision: _____

Legal Authority: MS §§ 245D.11, subd. 4; 245D.04, subd.2,(4) to (7), and 3, (8)

MRCI

POLICY AND PROCEDURE ON EMERGENCY USE OF MANUAL RESTRAINT-NOT ALLOWED

I. PURPOSE

The purpose of this policy is to promote service recipient rights and protect the health and safety of persons served during behavioral situations without the allowance of using an emergency use of manual restraint (EUMR). This policy will also promote appropriate and safe interventions needed when addressing behavioral situations.

II. POLICY

It is the policy of this company that emergency use of manual restraint is **not allowed** at any time. This policy contains content requirements of MN Statutes, section 245D.061, subdivision 9 for policy and procedures regarding emergency use of manual restraint. According to MN Statutes, section 245D.02, subdivision 8a, emergency use of manual restraint is defined as "using a manual restraint when a person poses an imminent risk of physical harm to self or others and is the least restrictive intervention that would achieve safety. Property damage, verbal aggression, or a person's refusal to receive or participate in treatment or programming on their own do not constitute an emergency."

III. PROCEDURE

Positive support strategies

A. MRCI will attempt to de-escalate a person's behavior before it poses an imminent risk of physical harm to self or others. Some of the following procedures could be used to de-escalate the situation and are options that could be implemented by staff. This is not a fully inclusive list of options that could include:
   1. A calm discussion between the person served and direct support staff regarding the situation, the person's feelings, their responses, and alternative methods to handling the situation, etc.
   2. A staff suggesting or recommending that the person participate in an activity they enjoy as a means to self-calm.
   3. A staff to suggest or remind that the person served has options that they may choose to spend time alone, when safety permits, as a means to self-calm.
   4. The individualized strategies that have been written into the person's *Support Plan* and/or *Support Plan Addendum*[1], or *Positive Support Transition Plan*.
   5. The implementation of instructional techniques and intervention procedures that are listed as **"Permitted actions and procedures"** as defined in Letter B of this **Positive support strategies** section.
   6. A combination of any of the above.

B. **Permitted actions and procedures** include the use of instructional techniques and intervention procedures used on an intermittent or continuous basis. If used on a continuous basis, it must be addressed in the person's *Support Plan Addendum*. These actions include:
   1. Physical contact or instructional techniques that are the least restrictive alternative possible to meet the needs of the person and may be used to:
      a. Calm or comfort a person by holding that person with no resistance from that person.
      b. Protect a person known to be at risk or injury due to frequent falls as a result of a medical condition.
      c. Facilitate the person's completion of a task or response when the person does not resist or the person's resistance is minimal in intensity or duration.
      d. Block or redirect a person's limbs or body without holding the person or limiting the person's movement to interrupt the person's behavior that may result in injury to self or others with less than 60 seconds of physical contact by staff.

1 Support plan previously known as Coordinated Services and Support Plan and/or Coordinated Services and Support Plan Addendum

e. Redirect a person's behavior when the behavior does not pose a serious threat to the person or others and the behavior is effectively redirected with less than 60 seconds of physical contact by staff.

2. Restraint may be used as an intervention procedure to:
   a. Allow a licensed health care professional to safely conduct a medical examination or to provide medical treatment ordered by a licensed health care professional.
   b. Assist in the safe evacuation or redirection of a person in the event of an emergency and the person is at imminent risk of harm.
   c. Position a person with physical disabilities in a manner specified in their *Support Plan Addendum.* Any use of manual restraint allowed in this paragraph must comply with the restrictions stated in the section of this policy **Restrictive Intervention**.
3. Use of adaptive aids or equipment, orthotic devices, or other medical equipment ordered by a licensed health professional to treat a diagnosed medical condition do not in and of themselves constitute the use of mechanical restraint.
4. Positive verbal correction that is specifically focused on the behavior being addressed.
5. Temporary withholding or removal of objects being used to hurt self or others.

Prohibited Procedures

MRCI and its staff are prohibited from using the following:

A. Chemical restraints
B. Mechanical restraints
C. Manual restraint
D. Time out
E. Seclusion
F. Any other aversive or deprivation procedures
G. As a substitute for adequate staffing
H. For a behavioral or therapeutic program to reduce or eliminate behavior
I. Punishment
J. For staff convenience
K. Prone restraint, metal handcuffs, or leg hobbles
L. Faradic shock
M. Speaking to a person in a manner that ridicules, demeans, threatens, or is abusive
N. Physical intimidation or a show of force
O. Containing, restricting, isolating, secluding, or otherwise removing a person from normal activities when it is medically contraindicated or without monitoring the person served
P. Denying or restricting a person's access to equipment and devices such as walkers, wheelchairs, hearing aids, and communication boards that facilitate the person's functioning. When the temporary removal of the equipment or device is necessary to prevent injury to the person or others or serious damage to the equipment or device, the equipment or device must be returned to the person as soon as imminent risk of injury or serious damage has passed.
Q. Painful techniques, including intentional infliction of pain or injury, intentional infliction of fear of pain or injury, dehumanization, and degradation
R. Hyperextending or twisting a person's body parts
S. Tripping or pushing a person
T. Requiring a person to assume and maintain a specified physical position or posture
U. Forced exercise
V. Totally or partially restricting a person's senses
W. Presenting intense sounds, lights, or other sensory stimuli
X. Noxious smell, taste, substance, or spray, including water mist
Y. Depriving a person of or restricting access to normal goods and services, or requiring a person to earn normal goods and services
Z. Token reinforcement programs or level programs that include a response cost or negative punishment component

AA. Using a person receiving services to discipline another person receiving services
BB. Using an action or procedure which is medically or psychologically contraindicated
CC. Using an action or procedure that might restrict or obstruct a person's airway or impair breathing, including techniques whereby individuals use their hands or body to place pressure on a person's head, neck, back, chest, abdomen, or joints
DD. Interfering with a person's legal rights, except as allowed by MN Statutes, section 245D.04, subdivision 3, paragraph (c).

Restrictive Intervention:
A restrictive intervention means prohibited procedures identified in MN Statutes, section 245D.06, subdivision 5; prohibited procedures identified in MN Rules, part 9544.006; and the emergency use of manual restraint.
A restricted procedure must not:

A. Be implemented with a child in a manner that constitutes sexual abuse, neglect, physical abuse, or mental injury as defined in MN Statutes, chapter 260E.
B. Be implemented with an adult in a manner that constitutes abuse or neglect as defined in MN Statutes, section 626.5572, subdivisions 2 or 17.
C. Be implemented in a manner that violates a person's rights identified in MN Statutes, section 245D.04.
D. Restrict a person's normal access to a nutritious diet, drinking water, adequate ventilation, necessary medical care, ordinary hygiene facilities, normal sleeping conditions, or necessary clothing, or to any protection required by state licensing standards and federal regulations governing the program.
E. Deny the person visitation or ordinary contact with legal counsel, a legal representative, or next of kin.
F. Be used as a substitute for adequate staffing, for the convenience of staff, as punishment, or as a consequence if the person refuses to participate in the treatment of services provided by MRCI.
G. Use prone restraint (that places a person in a face-down position).
H. Apply back or chest pressure while a person is in the prone or supine (face-up) position.
I. Be implemented in a manner that is contraindicated for any of the person's known medical or psychological limitations.

Positive Support Transition Plans **(PSTP)**
MRCI must and will develop a *Positive Support Transition Plan* on forms provided by the Department of Human Services and in the manner directed for a person served who requires intervention in order to maintain safety when it is known that the person's behavior poses an immediate risk of physical harm to self or others. A PSTP must be developed in accordance with MN Statutes, section 245D.06, subdivision 8 and MN Rules, part 9544.0070 for a person who has been subjected to three (3) incidents of EUMR within 90 days or four (4) incidents of EUMR within 180 days. This *Positive Support Transition Plan* will phase out any existing plans for the emergency use or programmatic use of restrictive interventions prohibited under MN Statutes, Chapter 245D and MN Rules, Chapter 9544.

Alternative measures to be used because manual restraints are not allowed in emergencies

A. This company does not allow the emergency use of manual restraint; therefore, the following alternative measures must be used by staff to achieve safety when a person's conduct poses an imminent risk of physical harm to self or others and less restrictive strategies have not achieved safety.
    1. Staff will continue to utilize the positive support strategies as defined in the **Positive support strategies** section listed above.
    2. If other persons served are in the immediate area of the person whose conduct poses an imminent risk of physical harm, staff will ask other persons to leave the area to another area of safety. If a person served is unable to leave the area independently, staff will provide the minimum necessary physical assistance to guide the person to safety.

3. Objects, that may potentially be used by the person that may be used which would increase the risk of physical harm, will be removed until the person is calm and then immediately returned. These objects may include sharps, fragile items, working implements, etc.
4. If the person's conduct continues to pose an imminent risk of physical harm to self or others, staff will call the mental health crisis line or mental health crisis intervention team (if available for the person) and follow any directions provided to them.
5. If no other positive strategy or alternative measure was effective in de-escalating the person's behavior, staff will contact "911" for assistance.
6. While waiting for law enforcement to arrive, staff will continue to offer the alternative measures listed here, if it remains safe to do so.

Emergency use of manual restraint

~~A.~~ If the positive support strategies were not effective in de-escalating or eliminating the person's behavior, staff will contact "911" for assistance. ~~, emergency use of manual restraint may be necessary. To use emergency use of manual restraint, the following conditions must be met:~~

~~1. Immediate intervention must be needed to protect the person or others from imminent risk of physical harm.~~
~~2. The type of manual restraint used must be the least restrictive intervention to eliminate the immediate risk of harm and effectively achieve safety.~~
~~3. The manual restraint must end when the threat of harm ends.~~

~~B. The following conditions, on their own, are not conditions for emergency use of manual restraint:~~

~~1. The person is engaging in property destruction that does not cause imminent risk of physical harm.~~
~~2. The person is engaging in verbal aggression with staff or others.~~
~~3. A person's refusal to receive or participate in treatment of programming.~~

~~C. If a person's licensed health care professional or mental health professional has determined that a manual restraint would be medically or psychologically contraindicated, MRCI will not use a manual restraint to eliminate the immediate risk of harm and effectively achieve safety. This statement of whether or not a manual restraint would be medically or psychologically contraindicated will be completed as part of service initiation planning.~~

~~**Monitoring of emergency use of manual restraint**~~

~~A. Each single incident of emergency use of manual restraint must be monitored and reported separately. For this understanding, an incident of emergency use of manual restraint is a single incident when the following conditions have been met:~~

~~1. After implementing the manual restraint, staff attempt to release the person at the moment staff believe the person's conduct no longer poses an imminent risk of physical harm to self or others and less restrictive strategies can be implemented to maintain safety.~~
~~2. Upon the attempt to release the restraint, the person's behavior immediately re-escalates and staff must immediately re-implement the restraint in order to maintain safety.~~

~~B. During an emergency use of manual restraint, MRCI will monitor a person's health and safety. Staff monitoring the manual restraint procedure will not be the staff implementing the procedure, when possible. A monitoring form will be completed by the staff person for each incident of emergency use of manual restraint to ensure:~~

~~1. Only manual restraints allowed according to this policy are implemented.~~
~~2. Manual restraints that have been determined to be contraindicated for a person are not implemented with that person.~~
~~3. Allowed manual restraints are implemented only by staff trained in their use.~~
~~4. The restraint is being implemented properly as required.~~
~~5. The mental, physical, and emotional condition of the person who is being manually restrained is~~

~~being assessed and intervention is provided when necessary to maintain the person's health and safety and prevent injury to the person, staff involved, or others involved.~~

Reporting of emergency use of manual restraint

A. ~~Reporting~~ While it is the policy of this agency to not allow the emergency use of manual restraint, if a staff witnesses or suspects an emergency use of manual restraint was used they should report the incident of emergency use of manual restraint will be completed according to the following process and will contain all required information per MN Statutes, sections 245D.06, subdivision 1 and 245D.061, subdivision 5.

B. Within 24 hours of the emergency use of manual restraint, MRCI will make a verbal report regarding the incident to the legal representative or designated emergency contact and case manager. If other persons served were involved in the incident, MRCI will not disclose any personally identifiable information about any other person when making the report unless MRCI has the consent of the person.

C. Within three (3) calendar days of the emergency use of manual restraint, the staff who implemented the emergency use of manual restraint will report, in writing, to the Designated Coordinator and/or Designated Manager the following information:
   1. The staff and person(s) served who were involved in the incident leading up to the emergency use of manual restraint.
   2. A description of the physical and social environment, including who was present before and during the incident leading up to the emergency use of manual restraint.
   3. A description of what less restrictive alternative measures were attempted to de-escalate the incident and maintain safety before the manual restraint was implemented. This description must identify the when, how, and how long the alternative measures were attempted before the manual restraint was implemented.
   4. A description of the mental, physical, and emotional condition of the person who was restrained, and other persons involved in the incident leading up to, during, and following the manual restraint.
   5. Whether there was any injury to the person who was restrained or other persons involved, including staff, before or as a result of the manual restraint use.
   6. Whether there was a debriefing with the staff, and, if not contraindicated, with the person who was restrained and other persons who were involved in or who witnessed the restraint, following the incident. The outcome of the debriefing will be clearly documented and if the debriefing could not occur at the time of the incident, the report will identify whether a debriefing is planned in the future.

D. Within five (5) working days of the emergency use of manual restraint, the Designated Manager will complete and document an internal review of each report of emergency use of manual restraint. The internal review will include an evaluation of whether:
   1. The person's served service and support strategies developed according to MN Statutes, sections 245D.07 and 245D.071 need to be revised.
   2. Related policies and procedures were followed.
   3. The policies and procedures were adequate.
   4. There is a need for additional staff training.
   5. The reported event is similar to past events with the persons, staff, or the services involved.
   6. There is a need for corrective action by MRCI to protect the health and safety of the person(s) served.

E. Based upon the results of the internal review, MRCI will develop, document, and implement a corrective action plan for the program designed to correct current lapses and prevent future lapses in performance by the individuals or MRCI, if any. The Designated Manager will ensure that the

corrective action plan, if any, must be implemented within 30 days of the internal review being completed.

F. Within five (5) working days after the completion of the internal review, the Designated Coordinator and/or Designated Manager will consult with the person's expanded support team following the emergency use of manual restraint. The purpose of this consultation is to:
   1. Discuss the incident and to define the antecedent or event that gave rise to the behavior resulting in the manual restraint and identify the perceived function the behavior served.
   2. Determine whether the person's served *Support Plan Addendum* needs to be revised to positively and effectively help the person maintain stability and to reduce or eliminate future occurrences requiring emergency use of manual restraint.

G. Within five (5) working dates of the expanded support team review, the Designated Coordinator and/or Designated Manager will submit, using the DHS online *Behavioral Intervention Reporting Form* (DHS-5148-ENG-1), the following information to the Department of Human Services and the Office of the Ombudsman for Mental Health and Developmental Disabilities:
   1. The report of the emergency use of manual restraint.
   2. The internal review and corrective action plan, if any.
   3. The written summary of the expanded support team's discussion and decision.

H. The following written information will be maintained in the person's service recipient record:
   1. The report of an emergency use of manual restraint incident that includes:
      a. Reporting requirements by the staff who implemented the restraint
      b. The internal review of emergency use of manual restraint and the corrective action plan, with information about implementation of correction within 30 days, if any
      c. The written summary of the expanded support team's discussion and decision
      d. The notifications to the expanded support team, the Department of Human Services, and the MN Office of the Ombudsman for Mental Health and Developmental Disabilities
   2. The PDF version of the completed and submitted DHS online *Behavioral Intervention Reporting Form* (DHS-5148-ENG-1). An email of this PDF version of the *Behavioral Intervention Reporting Form* will be sent to the MN-ITS mailbox assigned to the license holder.

Staff training requirements

A. MRCI recognizes the importance of having qualified and knowledgeable staff that are competently trained to uphold the rights of persons served and to protect persons' health and safety. All staff will receive orientation and annual training according to MN Statutes, section 245D.09, subdivisions 4, 4a, and 5. Orientation training will occur within the first 60 days of hire and annual training will occur within a period of 12 months.

B. Within 60 calendar days of hire, MRCI provides orientation on:
   1. The safe and correct use of manual restraint on an emergency basis according to the requirements in section 245D.061 or successor provisions, and what constitutes the use of restraints, time out, and seclusion, including chemical restraint; and
   2. Staff responsibilities related to prohibited procedures under section 245D.06, subdivision 5, MN Rules, part 9544.0060, or successor provisions, why such procedures are not effective for reducing or eliminating symptoms or undesired behavior, and why such procedures are not safe.

C. Before staff may implement an emergency use of manual restraint, and in addition to the training on this policy and procedure and the orientation and annual training requirements, staff must receive training on emergency use of manual restraints that incorporates the following topics:
   1. Alternatives to manual restraint procedures including techniques to identify events and environmental factors that may escalate conduct that poses an imminent risk of physical harm

to self or others.
2. De-escalation methods, positive support strategies, and how to avoid power struggles
3. Simulated experiences of administering and receiving manual restraint procedures allowed by MRCI on an emergency basis
4. How to properly identify thresholds for implementing and ceasing restrictive procedures
5. How to recognize, monitor, and respond to the person's physical signs of distress including positional asphyxia
6. The physiological and psychological impact on the person and the staff when restrictive procedures are used
7. The communicative intent of behaviors
8. Relationship building.

D. For staff that are responsible to develop, implement, monitor, supervise, or evaluate positive support strategies, *Positive Support Transition Plans*, or *Emergency Use of Manual Restraint*, the staff must complete a minimum of eight (8) hours of core training from qualified individuals prior to assuming these responsibilities. Core training must include the following:
   a. De-escalation techniques and their value
   b. Principles of person-centered service planning and delivery and how they apply to direct support services provided by staff
   c. Principles of positive support strategies such as positive behavior supports, the relationship between staff interactions with the person and the person's behavior, and the relationship between the person's environment and the person's behavior
   d. What constitutes the use of restraint, including chemical restraint, time out, and seclusion
   e. The safe and correct use of manual restraint on an emergency basis, according to MN Statutes, section 245D.061
   f. Staff responsibilities related to prohibited procedures under MN Statutes, section 245D.06, subdivision 5; why the procedures are not effective for reducing or eliminating symptoms or interfering behavior; and why the procedures are not safe
   g. Staff responsibilities related to restricted and permitted actions and procedure according to MN Statutes, section 245D.06, subdivisions 6 and 7
   h. Situations in which staff must contact 911 services in response to an imminent risk of harm to the person or others
   i. Procedures and forms staff must use to monitor and report use of restrictive interventions that are part of a *Positive Support Transition Plan*
   j. Procedures and requirements for notifying members of the person's expanded support team after the use of a restrictive intervention with the person
   k. Understanding of the person as a unique individual and how to implement treatment plans and responsibilities assigned to the license holder
   l. Cultural competence
   m. Personal staff accountability and staff self-care after emergencies.

E. Staff who develop positive support strategies, license holders, executives, managers, and owners in non-clinical roles, must complete a minimum of four (4) hours of additional training. Function-specific training must be completed on the following:
   a. Functional behavior assessment
   b. How to apply person-centered planning
   c. How to design and use data systems to measure effectiveness of care
   d. Supervision, including how to train, coach, and evaluate staff and encourage effective communication with the person and the person's support team.

F. License holders, executives, managers, and owners in non-clinical roles must complete a minimum of two (2) hours of additional training. Function-specific training must be completed on the following:
   a. How to include staff in organizational decisions

b. Management of the organization based upon person-centered thinking and practices and how to address person-centered thinking and practices in the organization
c. Evaluation of organizational training as it applies to the measurement of behavior change and improved outcomes for persons receiving services.

G. Annually, staff must complete four (4) hours of refresher training covering each of the training topics listed in items D, E, and F above.

H. For each staff, the license holder must document, in the personnel record, completion of core training, function-specific training, and competency testing or assessment. Documentation must include the following:
a. Date of training
b. Testing or assessment completion
c. Number of training hours per subject area
d. Name and qualifications of the trainer or instructor.

I. The license holder must verify and maintain evidence of staff qualifications in the personnel record. The documentation must include the following:
a. Education and experience qualifications relevant to the staff's scope of practice, responsibilities assigned to the staff, and the needs of the general population of persons served by the program; and
b. Professional licensure, registration, or certification, when applicable.

Policy reviewed and authorized by:

_____

Print name & title Signature

Date of last policy review: _____ Date of last policy revision: _____

MRCI

Legal Authority: MS §§ 245D.11, subd. 4; 245D.04, subd.2,(4) to (7), and 3, (8)

MRCI

EMERGENCY USE OF MANUAL RESTRAINT INCIDENT REPORT

Behavior intervention information
*This section to be completed within 3 calendar days by staff who implemented the emergency use of manual restraint (EUMR).
***MRCI's policy *does not* allow for staff to do Manual Restraints.**

Name of person served: **Date of the EUMR:** **Time of use:**

Name and title of staff completing this section:

Date of completion:

Location type:

Location address:

Staff and persons served who were involved in the incident leading up to the emergency use of manual restraint:
First name: Last name: Title:
First name: Last name: Title:
First name: Last name: Title:

Staff (if available) who monitored the person's health and welfare during the EUMR:
First name: Last name: Title:
*If an additional staff was not available to monitor the EUMR, the staff conducting the EUMR is responsible for monitoring the person's health and welfare during the EUMR.

The behavior the person displayed that required the use of an intervention included – choose all that apply:
☐ Physical aggression/physical assault ☐ Self-injury/self-harm
☐ Self-endangerment/risk to personal safety ☐ Property destruction/damage that could harm the person/others

Describe the behavior intervention used and the resulting outcome:

Length of use:

Describe the physical and social environment, including who was present *before* and *during* the incident leading up to the emergency use of manual restraint:

Describe what less restrictive alternative measures were attempted to de-escalate the incident and maintain safety before the manual restraint was implemented:

Identify when, how, and how long the alternative measures were attempted before the manual restraint was implemented:

Time when de-escalation occurred:
Length of time involved in de-escalation efforts: hours minutes

Describe the mental, physical, and emotional condition of the person who was restrained, and other persons involved in the incident *leading up to*, *during*, and *following* the manual restraint:

Was there any injury to the person who was restrained or other persons involved in the incident, including staff, *before* or *as a result* of the use of intervention? ☐ Yes ☐ No

If yes, indicate who was injured and what their injury(ies) were:

If yes, indicate what care was provided for the injured person(s):

Following the incident, was there a debriefing with the staff, and, if not contraindicated, with the person who was restrained and other persons who were involved in or who witnessed the restraint?
Staff: ☐ Yes ☐ No
Person served: ☐ Yes ☐ No
Other people: ☐ Yes ☐ No

If yes, describe the outcome of the debriefing:

If no, indicate whether a debriefing is planned:

Was a PRN psychotropic medication administered? ☐ Yes ☐ No

Was law enforcement or other first responders called? ☐ Yes ☐ No

Was there emergency psychiatric hospitalization? ☐ Yes ☐ No

Name of staff who implemented the EUMR _____ Date _____

Designated Coordinator review
*To be completed by the Designated Coordinator upon receipt and prior to the internal review. This information is used to assist in completion of the *Behavior Intervention Reporting Form (BIRF)*.

NPI/UMPI: Location number:

Contact person/provider phone number:

Contact person/provider email address:

Type of service that was provided at time of behavior intervention:

First name/middle initial/last name of the person:

PMI number of person who needed the intervention:

Date of birth: Gender:

County/Tribe Lead Agency funding the service:

County or Tribe where services are actually provided:

Diagnosis – choose all that apply: ☐ Developmental Disabilities ☐ Intellectual Disabilities (not from DD, i.e. BI)
☐ Physical/Medical Disabilities ☐ Mental Illness ☐ Elderly with Age-Related Impairments

Total number of current prescribed psychotropic medications (including PRN psychotropic medications):

Does the person currently have – choose all that apply: ☐ Positive Support Transition Plan
☐ Functional Behavior Assessment within the past 12 months ☐ Diagnostic Assessment within the past 12 months

Does this person have any conditions (medical or psychological) for which the physical behavioral intervention is contraindicated? ☐ Yes ☐ No

*This would be established in consultation with the person's support team. Please refer to the ~~*CSSP*~~ *Support Plan Addendum* for more information.

Does the person served require specialized or intensive behavior consultation and/or support services? ☐ Yes ☐ No

Does the person served require a plan for crisis respite placement? ☐ Yes ☐ No

Describe the plan to positively support the person and avoid the future use of behavior interventions:

Notifications

*The guardian/legal representative, designated emergency contact, and case manager must be notified within 24 hours of the emergency use of manual restraint.		
Include who was notified and the date and time of notification for the following persons or entities. Indicate 'NA' if it does not apply to the person:		
Parent:	Date:	Time:
Legal representative*:	Date:	Time:
Designated emergency contact*:	Date:	Time:
Case manager*:	Date:	Time:
DHS Licensing:	Date:	Time:
Common Entry Point (CEP)/MAARC:	Date:	Time:
Office of the Ombudsman:	Date:	Time:
Agency designated internal review team:	Date:	Time:
Expanded support team:	Date:	Time:

_____ _____

Name of person completing the notifications Date

Internal review of emergency use of manual restraint

*Within five (5) working days of the emergency use of manual restraint, the license holder's designated person who conducts internal reviews will complete the internal review of each report of the emergency use of manual restraint.

Date of internal review: This internal review must include an evaluation of the following information:

1. Whether the person's service and support strategies developed according to sections 245D.07 and 245D.071 need to be revised:

2. Whether related policies and procedures were followed:

3. Whether the policies and procedures were adequate:

4. Whether there is a need for additional staff training:

5. Whether the reported event is similar to past events with the persons, staff, or the services involved:

6. Whether there is a need for corrective action by the license holder to protect the health and safety of persons:

Based upon the results of the internal review, the license holder must develop, document, and implement a corrective action plan for the program designed to correct current lapses and prevent future lapses in performance by individuals or the license holder, if any.

Describe the corrective action plan here, if any:

*The corrective action plan, if any, must be implemented within 30 days of the internal review being completed. Date of implementation:

_____ _____
Name of person completing the internal review Date

Expanded support team review
*Within five (5) working days after the completion of the internal review, the license holder must consult with the expanded support team following the emergency use of manual restraint. This may be completed by the Designated Coordinator.

1. Discuss the incident reported and define the antecedent or event that gave rise to the behavior resulting in the manual restraint and identify the perceived function the behavior served:

2. Determine whether the person's ~~*Coordinated Service and*~~ *Support Plan Addendum* needs to be revised according to sections 245D.07 and 245D.071 to positively and effectively help the person maintain stability and to reduce or eliminate future occurrences requiring emergency use of manual restraint:

Legal representative: Date of discussion:
Case manager: Date of discussion:
Other professional (include name and title): Date of discussion:

_____ _____
Name of the Designated Coordinator and/or Designated Manager Date

Expanded review and reporting
*Within five (5) working days of the expanded support team review, the license holder must complete and submit to DHS the *Behavior Intervention Reporting Form* (DHS-5148-ENG-1). This submission meets the reporting requirements for reporting to DHS and the Office of the Ombudsman for Mental Health and Developmental Disabilities. This may be completed by the Designated Coordinator or Designated Manager and can be found on the following website: https://edocs.dhs.state.mn.us/lfserver/Secure/DHS-5148-ENG

Date of information submission:

Date the copy of the *Behavior Intervention Reporting Form* (DHS-5148-ENG-1) was sent to the support team:

MRCI

Grievance Policy

Policy

It is the policy of MRCI to ensure that people served by this program have the right to respectful and responsive services. We are committed to providing a simple complaint process for the people served in our program and their authorized or legal representatives to bring grievances forward and have them resolved in a timely manner.

Procedures

A. Service Initiation
A person receiving services and their case manager will be notified of this policy, and provided a copy, within five working days of service initiation.

B. How to File a Grievance
1. The person receiving services or person's authorized or legal representative:
   a. should talk to a staff person that they feel comfortable with about their complaint or problem;
   b. clearly inform the staff person that they are filing a formal grievance and not just an informal complaint or problem; and
   c. may request staff assistance in filing a grievance.
2. If the person or person's authorized or legal representative does not believe that their grievance has been resolved they may bring the complaint to the highest level of authority in this program. Complaints will be handled through a written process only.
   - That person is Rebecca Bieck, Director of CDS.
   - She may be reached at:
     1961 Premier Drive
     Suite 318
     Mankato, MN 56001
     Email: rbieck@mymrci.org
     Phone: (507) 386-5704

C. Response by the Program
1. Upon request, staff will provide assistance with the complaint process to the service recipient and their authorized representative. This assistance will include:
   a. the name, address, and telephone number of outside agencies to assist the person; and
   b. responding to the complaint in such a manner that the service recipient or authorized representative's concerns are resolved.
2. This program will respond promptly to grievances that affect the health and safety of service recipients.
3. All other complaints will be responded to within 10 calendar days of the receipt of the complaint.
4. All complaints will be resolved within 10 calendar days of the receipt.
5. If the complaint is not resolved within 10 calendar days, this program will document the reason for the delay and a plan for resolution.
6. Once a complaint is received, the program is required to complete a complaint review. The complaint review will include an evaluation of whether:
   a. related policy and procedures were followed;

b. related policy and procedures were adequate;
c. there is a need for additional staff training;
d. the complaint is similar to past complaints with the persons, staff, or services involved; and
e. there is a need for corrective action by the license holder to protect the health and safety of persons receiving services.

7. Based on this review, the license holder must develop, document, and implement a corrective action plan designed to correct current lapses and prevent future lapses in performance by staff or the license holder, if any.
8. The program will provide a written summary of the complaint and a notice of the complaint resolution to the person and case manager that:
   a. identifies the nature of the complaint and the date it was received;
   b. includes the results of the complaint review; and
   c. identifies the complaint resolution, including any corrective action.

D. The complaint summary and resolution notice must be maintained in the person's record.

Policy reviewed and authorized by:

_____

Print Name & Title Signature

Date of last policy review: _____ Date of last policy revision: _____

Legal Authority: Minn. Stat. § 245D.10, subd. 2 and 4

MRCI

INCIDENT AND EMERGENCY REPORT

Identifying data
Program or person served:

Phone: Address:

Type of incident or emergency (check all that apply)

☐ Serious injury*	☐ Any mental health crisis that requires the program to call "911" or a mental health crisis intervention team	☐ Conduct by a person served against another person served (see 245D.02, subd. 11 for severity)
☐ ~~Medical emergency~~ this cell merged below		
☐ ~~Unexpected serious illness~~ this cell merged below	☐ Maltreatment of a minor	
☐ Medical Emergency, unexpected serious illness, or significant unexpected changes in an illness or medical condition of a person that requires the program to call "911," physician ~~treatment~~, advanced practice registered nurse, or physician assistant treatment, or hospitalization	☐ Maltreatment of a vulnerable adult	☐ Sexual activity between persons served involving force or coercion
		☐ Death of a person served*
	☐ An act or situation involving a person that requires the program to call "911," law enforcement, or the fire department	☐ Emergency use of manual restraint (complete the *EUMR Incident Report* form)
	☐ A person's unauthorized or unexplained absence from a program	☐ Emergency (state specific type):

*Reporting of these incidents must also be made to MN Department of Human Services and MN Office of the Ombudsman.

Date of incident: Time of incident: (indicate am or pm)

Location of incident:

Describe the incident and emergency including the effect on the person (delete unused rows)

Describe the response to the incident or emergency (delete unused rows)

Name and title of staff who responded	Date

Required notifications: completed within 24 hours of discovery or receipt of information that the incident occurred

Legal representative:	Date:	Time:	am/pm	☐ Left message
Case manager:	Date:	Time:	am/pm	☐ Left message
Designated emergency contact:	Date:	Time:	am/pm	☐ Left message
Rule 203 licensor (family foster care only): ☐ **N/A**	Date:	Time:	am/pm	☐ Left message
Other: ☐ **N/A**	Date:	Time:	am/pm	☐ Left message
DHS Licensing Division: ☐ **N/A**	Date:	Time:	am/pm	☐ Left message
MN Office of the Ombudsman: ☐ **N/A**	Date:	Time:	am/pm	☐ Left message
Common Entry Point/Child Protection Agency ☐ **N/A** Name of intake worker:	Date:	Time:	am/pm	
Was an internal maltreatment report filed? ☐ Yes ☐ No, if no, why:				

Name of staff person who notified the persons or entities _____ Date _____

Designated Manager review and recommendation

1. Was the person's ~~*Coordinated Service and*~~ *Support Plan Addendum* implemented as applicable?
   ☐ Yes ☐ No: if no address in the corrective action section of this review

   Were policies and procedures implemented as applicable?
   ☐ Yes ☐ No: if no address in the corrective action section of this review

2. Identification of patterns:

3. Is corrective action necessary based upon the review? ☐ Yes ☐ No: if yes, what corrective action will be implemented as necessary to reduce occurrences:

Designated Manager _____ Date _____

POLICY AND PROCEDURE ON RESPONDING TO AND REPORTING INCIDENTS

I. PURPOSE

The purpose of this policy is to provide instructions to staff for responding to and reporting incidents.

II. POLICY

MRCI will respond to incidents as defined in MN Statutes, section 245D.02, subdivision 11, that occur while providing services to protect the health and safety of and minimize risk of harm to the person(s) served. Staff will address all incidents according to the specific procedure outlined in this policy and act immediately to ensure the safety of persons served. After the situation has been resolved and/or the person(s) involved are no longer in immediate danger, staff will complete the necessary documentation in order to comply with licensing requirements on reporting and to assist in developing preventative measures. For emergency response procedures, staff will refer to the *Policy and Procedure on Emergencies*.

All staff will be trained on this policy and the safe and appropriate response and reporting of incidents. In addition, program sites will have contact information of a source of emergency medical care and transportation readily accessible. In addition, a list of emergency phone numbers will be posted in a prominent location and emergency contact information for persons served at the facility including each person's representative, physician, and dentist is readily available.

III. PROCEDURE

Defining incidents

A. An incident is defined as an occurrence which involves a person and requires the program to make a response that is not a part of the program's ordinary provision of services to that person, and includes:
   1. Serious injury of a person as determined by MN Statutes, section 245.91, subdivision 6:
      a. Fractures
      b. Dislocations
      c. Evidence of internal injuries
      d. 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
      e. Lacerations involving injuries to tendons or organs and those for which complications are present
      f. Extensive second degree or third degree burns and other burns for which complications are present
      g. Extensive second degree or third degree frostbite and others for which complications are present
      h. Irreversible mobility or avulsion of teeth
      i. Injuries to the eyeball
      j. Ingestion of foreign substances and objects that are harmful
      k. Near drowning
      l. Heat exhaustion or sunstroke
      m. Attempted suicide
      n. All other injuries 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
   2. Death of a person served.

3. Any medical emergency, unexpected serious illness, or significant unexpected changes in an illness or medical condition of a person that requires the program to call "911," physician, advanced practice registered nurse, or a physician assistant treatment, or hospitalization.
4. Any mental health crisis that requires the program to call "911," a mental health crisis intervention team, or a similar mental health response team or service when available and appropriate.
5. An act or situation involving a person that requires the program to call "911," law enforcement, or the fire department.
6. A person's unauthorized or unexplained absence from a program.
7. Conduct by a person served against another person served that:
   a. Is so severe, pervasive, or objectively offensive that it substantially interferes with a person's opportunities to participate in or receive service or support
   b. Places the person in actual and reasonable fear of harm
   c. Places the person in actual and reasonable fear of damage to property of the person
   d. Substantially disrupts the orderly operation of the program
8. Any sexual activity between persons served involving force or coercion as defined under MN Statutes, section 609.341, subdivisions 3 and 14.
9. Any emergency use of manual restraint as identified in MN Statutes, section 245D.061.
10. A report of alleged or suspected maltreatment of a minor or vulnerable adult under MN Statutes, section 626.557 or chapter 260E.

Responding to incidents

A. Staff will respond to incidents according to the following plans. For incidents including death of a person served, maltreatment, and emergency use of manual restraints, staff will follow the applicable policy and procedure:
   1. **Death of a person served**: *Policy and Procedure on the Death of a Person Served*
   2. **Maltreatment**: *Policy and Procedure on Reporting and Review of Maltreatment of Vulnerable Adults* or *Policy and Procedure on Reporting and Review of Maltreatment of Minors*
   3. **Emergency use of manual restraint**: *Policy and Procedure on Emergency Use of Manual Restraint*

B. **Any medical emergency (including serious injury), unexpected serious illness, or significant unexpected changes in an illness or medical condition of a person that requires the program to call "911," physician treatment, or hospitalization**
   1. Staff will first call "911" if they believe that a person is experiencing a medical emergency (including serious injury), unexpected serious illness, or significant unexpected change in illness or medical condition that may be life threatening and provide any relevant facts and medical history.
   2. Staff will give first aid and/or CPR to the extent they are qualified, when it is indicated by their best judgment or the "911" operator, unless the person served has an advanced directive. Staff will refer to the *Policy and Procedure on the Death of a Person Served* for more information.
   3. Staff will notify the Designated Coordinator and/or Designated Manager or designee who will assist in securing any staffing coverage that is necessary.
   4. If the person is transported to a hospital, staff will either accompany the person or go to the hospital as soon as possible. Staff will not leave other persons served alone or unattended.
   5. Staff will ensure that a completed *Medical Referral* form and all insurance information including current medical insurance card(s) accompany the person.
   6. Staff will remain at the hospital and coordinate an admission to the hospital. If the person served is not to be admitted to the hospital, staff will arrange for transportation home.

7. Upon discharge from the hospital or emergency room, staff transporting to the program site will coordinate with the assigned nurse or nurse consultant, Designated Coordinator and/or Designated Manager or designee and ensure that:
    a. All new medications/treatments and cares have been documented on the *Medical Referral* form
    b. All medications or supplies have been obtained from the pharmacy
    c. All new orders have been recorded on the monthly medication sheet
    d. All steps and findings are documented in the program and health documentation, as applicable
8. If the person's condition does not require a call to "911," but prompt medical attention is necessary, staff will consider the situation as health threatening and will call the person's physician, licensed health care professional, or urgent care to obtain treatment.
9. Staff will contact the assigned nurse or nurse consultant or Designated Coordinator and/or Designated Manager or designee and will follow any instructions provided including obtaining necessary staffing coverage.
10. Staff will transport the person to the medical clinic or urgent care and will remain with the person. A *Medical Referral* form will be completed at the time of the visit.
11. Upon return from the medical clinic or urgent care, staff will coordinate with the assigned nurse or nurse consultant, Designated Coordinator and/or Designated Manager or designee and ensure that:
    a. All new medications/treatments and cares have been documented on the *Medical Referral* form
    b. All medications or supplies have been obtained from the pharmacy
    c. All new orders have been recorded on the monthly medication sheet
    d. All steps and findings are documented in the program and health documentation, as applicable

C. **Any mental health crisis that requires the program to call "911," a mental health crisis intervention team, or a similar mental health response team or service when available and appropriate.**
1. Staff will implement any crisis prevention plans specific to the person served as a means to de-escalate, minimize, or prevent a crisis from occurring.
2. If a mental health crisis were to occur, staff will ensure the person's safety, and will not leave the person alone if possible.
3. Staff will contact "911," a mental health crisis intervention team, or a similar mental health response team or service when available and appropriate, and explain the situation and that the person is having a mental health crisis.
4. Staff will follow any instructions provided by the "911" operator or the mental health crisis intervention team contact person.
5. Staff will notify the Designated Coordinator and/or Designated Manager or designee who will assist in securing any staffing coverage that is necessary.
6. If the person is transported to a hospital, staff will either accompany the person or go to the hospital as soon as possible. Staff will not leave other persons served alone or unattended.
7. Staff will ensure that a completed *Medical Referral* form and all current insurance information including current medical insurance card(s) accompany the person.
8. Staff will remain at the hospital and coordinate an admission to the hospital. If the person served is not to be admitted to the hospital, staff will arrange for transportation home.
9. Upon discharge from the hospital or emergency room, staff transporting to the program site will coordinate with the assigned nurse or nurse consultant, Designated Coordinator and/or Designated Manager or designee and ensure that:
    a. All new medications/treatments have been documented on the *Medical Referral* form
    b. All medications or supplies have been obtained from the pharmacy

c. All new orders have been recorded on the monthly medication sheet
d. All steps and findings are documented in the program and health documentation, as applicable

D. **An act or situation involving a person that requires the program to call "911," law enforcement, or the fire department**
1. Staff will contact "911" immediately if there is a situation or act that puts the person at imminent risk of harm.
2. Staff will immediately notify the Designated Coordinator and/or Designated Manager or designee of any "911," law enforcement, or fire department involvement or intervention.
3. If a person served has been the victim of a crime, staff will follow applicable policies and procedures for reporting and reviewing maltreatment of vulnerable adults or minors.
4. If a person has been sexually assaulted, staff will discourage the person from bathing, washing, or changing clothing. Staff will leave the area where the assault took place untouched, if it is under the company's control.
5. If a person served is suspected of committing a crime or participating in unlawful activities, staff will follow the person's ~~*Coordinated Service and*~~ *Support Plan Addendum* when possible criminal behavior has been addressed by the support team.
6. If a person served is suspected of committing a crime and the possibility has not been addressed by the support team, the Designated Coordinator and/or Designated Manager will determine immediate actions and contact support team members to arrange a planning meeting.
7. If a person served is incarcerated, the Designated Coordinator and/or Designated Manager or designee will provide the police with information regarding vulnerability, challenging behaviors, and medical needs.

E. **Unauthorized or unexplained absence of a person served from a program**
1. Based on the person's supervision level, staff will determine when the person is missing from the program site or from supervision in the community.
2. Staff will immediately call "911" if the person is determined to be missing. Staff will provide the police with information about the person's appearance, last known location, disabilities, and other information as requested.
3. Staff will immediately notify the Designated Coordinator and/or Designated Manager or designee. Together a more extensive search will be organized, if feasible, by checking locations where the person may have gone.
4. The Designated Coordinator and/or Designated Manager or designee will continue to monitor the situation until the individual is located.
5. If there is reasonable suspicion that abuse and/or neglect led to or resulted from the unauthorized or unexplained absence, staff will report immediately in accordance with applicable policies and procedures for reporting and reviewing maltreatment of vulnerable adults or minors.

F. **Conduct by a person served against another person served**
1. Staff will immediately enlist the help of additional staff if they are available and intervene to protect the health and safety of persons involved.
2. Staff will redirect persons to discontinue the behavior and/or physically place themselves between the aggressor(s) using the least intrusive methods possible in order to de-escalate the situation.
3. If the aggressor has a behavior plan in place, staff will follow the plan as written in addition to the methodologies that may be provided in the ~~*Coordinated Service and*~~ *Support Plan Addendum.*
4. Staff will remove the person being aggressed towards to an area of safety.

5. If other least restrictive alternatives were ineffective in de-escalating the aggressors' conduct and immediate intervention is needed to protect the person or others from imminent risk of physical harm, staff will follow the *Policy and Procedure on Emergency Use of Manual Restraint* and/or staff will call "911."
6. If the ordinary operation of the program is disrupted, staff will manage the situation and will return to the normal routine as soon as possible.
7. To the extent possible, staff will visually examine persons served for signs of physical injury and document any findings.
8. If the conduct results in injury, staff will provide necessary treatment according to their training.

G. **Sexual activity between persons served involving force or coercion**
1. Staff will follow any procedures as directed by the *Individual Abuse Prevention Plans* and/or ~~*Coordinated Service and*~~ *Support Plan Addendums*, as applicable.
2. Staff will immediately intervene in an approved therapeutic manner to protect the health and safety of the persons involved if there is obvious coercion or force involved, or based on the knowledge of the persons involved, that one of the persons may have sexually exploited the other.
3. If the persons served are unclothed, staff will provide them with a robe or other appropriate garment and will discourage the person from bathing, washing, changing clothing or redressing in clothing that they were wearing.
4. Staff will leave the area where the sexual activity took place untouched if it is under the MRCI's control.
5. Staff will call "911" in order to seek medical attention if necessary and inform law enforcement.
6. To the extent possible, staff will visually examine persons served for signs of physical injury and document any findings.
7. If the incident resulted in injury, staff will provide necessary treatment according to their training.

Reporting incidents

A. Staff will first call "911" if they believe that a person is experiencing a medical emergency that may be life threatening. In addition, staff will first call "911," a mental health crisis intervention team for a person experiencing a mental health crisis, or a similar mental health response team or service when available and appropriate.

B. Staff will immediately notify the Designated Coordinator and/or Designated Manager that an incident or emergency has occurred and follow direction issued to them and will document the incident or emergency on an *Incident and Emergency Report* and any related program or health documentation. Each *Incident and Emergency Report* will contain the required information as stated in the *Policy and Procedure on Reviewing Incidents and Emergencies.*

C. When the incident or emergency involves more than person served, MRCI and staff will not disclose personally identifiable information about any other person served when making the report to each person and/or legal representative and case manager unless MRCI has the consent of the person and/or legal representative.

D. The Designated Coordinator and/or Designated Manager will maintain information about and report incidents to the legal representative or designated emergency contact and case manager within 24 hours of an incident occurring while services are being provided, within 24 hours of discovery or receipt of information that an incident occurred, unless MRCI has reason to know that the incident has already been reported, or as otherwise directed in the person's ~~*Coordinated Service and*~~ *Support Plan* and/or ~~*Coordinated Service and*~~ *Support Plan Addendum*.

E. A report will be made to the MN Office of the Ombudsman for Mental Health and Developmental Disabilities and the Department of Human Services Licensing Division within 24 hours of the incident, or receipt of the information that the incident occurred, unless the MRCI has reason to know that the incident has already been reported, by using the required reporting forms. A report made be made using the Office of the Ombudsman's Death Report webform or Serious Injury webform. Forms to fax include *Death Reporting Form, Serious Injury Form,* and *Death or Serious Injury Report FAX Transmission Cover Sheet*. Incidents to be reported include:
   1. Serious injury as determined by MN Statutes, section 245.91, subdivision 6.
   2. Death of a person served.

F. Verbal reporting of an emergency use of manual restraint will occur within 24 hours of the occurrence. Further reporting procedures will be completed according to the *Policy and Procedure on Emergency Use of Manual Restraint* which includes the requirements of reporting incidents according to MN Statutes, sections 245D.06, subdivision 1 and 245D.061.

G. Within 24 hours of reporting maltreatment, MRCI will inform the case manager of the nature of the activity or occurrence reported and the agency that received the report. MRCI and staff will follow the applicable policy and procedure on reporting maltreatment for vulnerable adults or minors, as applicable.

MRCI

MEDICATION ADMINISTRATION RECORD REVIEW

Name: Program site:

Date of review: Frequency of review:

Name and title of person completing the review:

When assigned responsibility for medication administration, the company will ensure that the information maintained in the medication administration record is current and regularly reviewed to identify medication administration errors. This review must be conducted every three months or more frequently as directed by the ~~*Coordinated Service and*~~ *Support Plan* and/or ~~*Coordinated Service and*~~ *Support Plan Addendum* or as requested by the person served and/or legal representative.

Review area	Evaluation	Write correction action plan and recheck date, if necessary
Health-related information	Person's health-related information is current. ☐ Yes ☐ No Indicate what is not current and what the correct information is:	
Monthly medication sheets	Last three months reviewed: Month: Month: Month: Changes to medication or treatment orders were made to the monthly medication sheet. ☐ Yes ☐ No If concerns are noted regarding the medication sheets, indicate what the concern is: Staff have initialed each date and time of medication administration, if not, indicate what dates/times have not been initialed:	
Medication errors	Record reviewed to identify medication administration errors (already recorded and reported; and not yet reported). ☐ Yes ☐ No At the time of the med error, it was reported and recorded as required by the company policy and the *CSSP Addendum*. ☐ Yes ☐ No	

	Are med errors related to the person's refusal or failure to take or receive medication or treatment as prescribed? ☐ Yes ☐ No	
Referrals	Referrals completed since last medication administration record review: 1. 2. If any follow up was ordered on the referrals, was this completed? If not, include the referral, date, and what was not completed as ordered:	
Medication and treatment orders and protocols	Indicate what medication or treatment was ordered, changed, or discontinued: Are there any concerns with the medication or treatment orders? If so, please specify: *Standing Order Medication List* is current. ☐ Yes ☐ No Protocols (i.e. seizure, diabetic) are current and effective. ☐ Yes ☐ No Are there any concerns regarding the person's refusal to take their medication or receive treatment? If so, please specify:	
Self-administration plans	Are there any concerns regarding the person's self-administration of medications or treatments? If so, please specify:	
Medication storage, supply, and systems	Medication is current (not expired) and there is adequate supply. ☐ Yes ☐ No Medication is being stored adequately and according to policy. ☐ Yes ☐ No Are there any concerns regarding the safe and effective use of medication systems? If so, please specify:	
Based upon this review and the items noted, the company must develop and implement a plan to correct patterns of medication administration errors.		

This plan includes:

MRCI

POLICY AND PROCEDURE ON SAFE MEDICATION ASSISTANCE AND ADMINISTRATION

Program Name: _____

I. PURPOSE

The purpose of this policy is to establish guidelines to promote the health and safety of persons served by ensuring the safe assistance and administration of medication and treatments or other necessary procedures.

II. POLICY

MRCI is responsible for meeting health service needs including medication-related services of persons as assigned in the ~~*Coordinated Service and*~~ *Support Plan* and/or ~~*Coordinated Service and*~~ *Support Plan Addendum.*

Persons served will be encouraged to participate in the process of medication administration to the fullest extent of their abilities, unless otherwise noted in the ~~*Coordinated Service and*~~ *Support Plan* and/or ~~*Coordinated Service and*~~ *Support Plan Addendum.* The following procedures contain information on medication-related services for the administration of medication as well as the assistance staff may provide to a person who self-administers their own medication.

MRCI will obtain written authorization from the person served and/or client representative as to whom will set up, assist, and administer medications or treatments, including psychotropic medications, and will re-obtain this authorization annually. If authorization by the person served and/or client representative is refused, this person will not administer the medication or treatment. This refusal will be immediately reported to the person's prescriber and staff will follow any directives or orders given by the prescriber.

All medications and treatments will be administered according to this policy and procedure and MRCI's medication administration training curriculum.

III. PROCEDURE

Staff training on medication administration

A. When medication administration has been assigned to the representative or person served as stated in the ~~*Coordinated Service and*~~ *Support Plan* and/or ~~*Coordinated Service and*~~ *Support Plan Addendum*, all staff who will assist or administer medications to persons served will receive training and demonstrate competency as well as reviewing this policy and procedure. The training is done by an elected staff or the client representative as indicated in the *Coordinated Service and Support Plan Addendum.*

B. All unlicensed staff, prior to the administration of medication, must successfully complete a medication administration training course developed by a registered nurse, clinical nurse specialist in psychiatric and mental health nursing, certified nurse practitioner, physician's assistant, or physician. The training curriculum must incorporate an observed skill assessment conducted by the trainer to ensure staff demonstrate the ability to safely and correctly follow medication procedures.

C. Upon completion of this course and prior to administering medications, staff will be required to demonstrate medication administration established for persons served specifically at the program site, if this has not already been completed.

D. This training will be completed for each staff person during orientation, within the first 60 days of hire, and annually thereafter and will include a review of this policy and procedure. However, staff

who demonstrate a pattern of difficulty with accurate medication administration may be required to complete retraining at a greater frequency and/or be denied the responsibility of administering medications.

E. Documentation for this training and the demonstrated competency will be maintained in each staff person's Host Home file.

Medication set up and contents of the medication administration record

A. When setting up medication for later administration, staff will follow written instructions provided from the pharmacy or prescriber. These written instructions from the prescriber can include a prescription label or the prescriber's written or electronically recorded order for the prescription.

B. Staff will document the following information in the person's served medication administration record:
   1. Dates of medication set up.
   2. Name of medication.
   3. Quantity of dose.
   4. Times to be administered.
   5. Route of administration at the time of set up.
   6. When the person will be away from the program site, to whom the medication was given.

C. Any concerns with medication received from the pharmacy will be immediately communicated to the pharmacy and/or prescriber and instructions followed. The Designated Coordinator and/or Designated Manager will be notified of any concerns or discrepancies regarding medication and medication set up.

D. Additional information that will be maintained in a person's medication administration record include:
   1. Information on the current prescription labels or the prescriber's current written or electronically recorded order or prescription that includes the:
      a. Person's name
      b. Description of the medication or treatment to be provided
      c. Frequency of administration
      d. Other information needed to safely and correctly administer medication or treatment to ensure effectiveness
   2. Easily accessible information on risks and other side effects that are reasonable to expect and any contraindications to the medications use.
   3. Possible consequences if the medication or treatment is not taken or administered as directed.
   4. Instruction on when and to whom to report:
      a. If a dose of medication is not administered or treatment is not performed as prescribed, whether by staff error, the person's error, or by the person's refusal
      b. The occurrence of possible adverse reactions to the medication or treatment
   5. Notation of any occurrence of a dose of medication not being administered or treatment not performed as prescribed, whether by staff error, the person's error, or by the person's refusal, or of adverse reactions, and when and to whom the report was made.
   6. Notation of when a medication or treatment is started, administered, changed, or discontinued.
   7. Medical and mental health referral forms, protocols, results of lab work or x-rays, etc.

Medication assistance

A. There may be occasions when Designated Medication Staff is assigned responsibility solely for medication assistance to enable a person served to self-administer medication or treatments when the person is capable of directing their own care or when the person's client representative is present and able to direct care for the person.

B. Standards regarding obtaining written authorization and staff training on medication administration and this policy still apply for medication assistance as they do for medication administration.

C. If medication assistance is assigned in the ~~*Coordinated Service and*~~ *Support Plan* and/or ~~*Coordinated Service and*~~ *Support Plan Addendum*, staff may:
   1. Bring to the person and open a container of previously set up medications, empty the container into the person's hand, or open and give the medication in the original container to the person.
   2. Bring to the person food or liquids to accompany the medication.
   3. Provide reminders to take regularly scheduled medication or perform regularly scheduled treatments and exercises.

Medication administration

A. Medication may be administered within 60 minutes before or after the prescribed time. For example, a medication ordered to be given at 7:00 am may be administered between 6:00 am and 8:00 am.

B. Medications ordered to be given as an "AM medication" and/or "PM medication" may be administered at a routine daily time. The routine time may fluctuate up to two hours in order to accommodate the person's schedule. For example, if a person typically receives their medication at 7:00 am, then on the weekends, the medication may be given between 5:00 am and 9:00 am.

C. Staff administering medication must know or be able to locate medication information on the intended purpose, side effects, dosage, and special instructions.

D. General and specific procedures on administration of medication by routes are included at the end of this policy. Routes included are:
   1. Oral tablet/capsule/lozenge.
   2. Liquid medication.
   3. Buccal medication.
   4. Inhaled medication.
   5. Nasal spray medication.
   6. Eye medication.
   7. Ear drop medication.
   8. Topical medication.

Injectable medications

A. Injectable medications may be administered at the residence to a person served according to their prescriber's order and written instructions are provided. The prescriber's order and written instructions will be maintained in the service recipient record.

B. A registered nurse or licensed practical nurse will administer subcutaneous or intramuscular injections. When a registered nurse or licensed practical nurse is not available, a supervising registered nurse with a prescriber's order can delegate the administration of a subcutaneous injectable medication to the client representative.

C. An authorization/agreement that must be signed by the Designated Coordinator and/or Designated Manager, the prescriber, and the person served and/or client representative will be maintained in the service recipient record. This authorization will specify:
   1. What subcutaneous injection may be given.
   2. When and how the injection may be given.
   3. That the prescriber retains responsibility for the company to give the injection.

D. Only a licensed health care professional is allowed to administer psychotropic medications by

injection. This responsibility will not be delegated to unlicensed staff.

Psychotropic medication

A. The use of psychotropic medication will be clearly documented in the *Coordinated Service and Support Plan* and/or *Coordinated Service and Support Plan Addendum* and based upon the prescriber's current written or electronically recorded prescription.

B. The Designated Coordinator and/or Designated Manager will develop, implement, and maintain the following information in the person's ~~*Coordinated Service and*~~ *Support Plan Addendum* according to MN Statutes, sections 245D.07 and 245D.071. This information includes:
   1. A description of the target symptoms that the psychotropic medication is to alleviate.
   2. Documentation methods that the company will use to monitor and measure changes to these target symptoms, if required by the prescriber.
   3. Data collection of target symptoms and reporting on the medication and symptom-related data, as instructed by the prescriber, a minimum of quarterly or as requested by the person and/or client representative. This reporting will be made to the expanded support team.

C. If the person and/or client representative refuse to authorize the administration of a psychotropic medication as ordered by the prescriber, no one will administer the medication and the client representative will notify the prescriber as expediently as possible. After reporting the refusal to the prescriber, the company must follow any directives or orders given by the prescriber. A court order must be obtained to override the refusal. Refusal to authorize administration of a specific psychotropic medication is not grounds for service termination and does not constitute an emergency.

Medication documentation and charting

A. Staff will transcribe a prescriber's new, changed, and discontinued medication/treatment orders to the monthly medication sheet by:
   1. Comparing the label on the medication with the prescriber's to ensure they match. Any discrepancy must be reported to the pharmacy immediately.
   2. Copying any new medication/treatment or change from the original prescriber's orders to the monthly medication sheet.
   3. Implementing any change in a current medication/treatment must be rewritten as a new order; the existing entry may not be changed or edited, but must be "Discontinued."
   4. Entering the medication/treatment name, dose, route, frequency, and times to be administered.
   5. Drawing an arrow to the start date for each assigned time.
   6. Writing the date the medication is to start, the name of the prescriber who ordered the medication, and the initials of the person making the entry, on the line just below the arrows or under the order on a separate line.
   7. Discontinuing a medication/treatment as ordered by writing "D/C" or "Discontinued," the date, the prescriber's name, and the initials of the person making the entry on the line just below the arrow.
   8. Completing any applicable health documentation regarding the entry and notifying the Designated Coordinator and/or Designated Manager.

B. Staff will document a medication given from the *Standing Order Medications List* form by:
   1. Writing the medication on the monthly medication sheet exactly as it is written on the *Standing Order Medications List*.
   2. Initialing in the correct box for the date the medication was administered and the time.
   3. Documenting what medication/treatment was administered, the dose, the reason it was given, and the effect in the health documentation one hour after the medication was given.
   4. Following any special instructions noted on the *Standing Order Medications* form, notifying the assigned nurse, nurse consultant, or prescriber as directed.

C. Staff will document administration of medications/treatments on the monthly medication sheet by:
   1. Ensuring the person's name, allergies, prescriber's name, month, and year are on the monthly medication sheet.
   2. Completing documentation on the monthly medication sheet in black ink.
   3. Ensuring white-out, erasing, or disfigurement, such as scratching out are not used at any time.

D. Each month, staff administering and documenting medication/treatment administration will enter their initials, full name, and title initials in the designated location on the monthly medication sheet.

Coordination and communication with prescriber

A. As part of medication assistance and administration, the Designated Medication Staff will ensure that clear and accurate documentation of prescription orders has been obtained by the prescriber in written format.
B. Initiations, dosage changes, or discontinuations of medications will be coordinated with the prescriber and discussed as needed to ensure staff and/or the person served has a clear understanding of the order. If the order has only been done verbally, staff will request a written or electronically recorded copy from the prescriber. Staff will not make any changes to medications or treatment orders unless there is a written or electronically recorded copy.

C. All prescriber instructions will be implemented as directed and within required timelines by staff and/or the person served and documented in related health documentation.

D. Concerns regarding medication purpose, dosage, potential or present side effects, or other medication-related issues will be promptly communicated to the prescriber by staff, the Designated Medication Staff, assigned nurse, or nurse consultant.

E. Any changes to the physical or mental needs of the person as related to medication will be promptly made to the prescriber in addition to the client representative and case manager.

Coordination of medication refills and communicating with the pharmacy

A. The Designated medication staff or other designated staff person will be responsible for checking medication supply routinely to ensure adequate amount for administration.

B. Medications and supplies that have a seven (7) day supply or less will be called into the pharmacy for reorder by a designated staff person. If a person served is able to reorder medications for themselves as part of self-administration, staff will provide the level of assistance necessary to ensure accurate reordering. This may include but is not limited to dialing the telephone, communicating the name, prescription number, or dose, and coordinating a pick up time.

C. Some pharmacies may automatically refill prescriptions of persons served. If this is the case, staff will contact the pharmacy if a medication or treatment is discontinued.

D. The number of the pharmacy from where medications are supplied will be maintained in each person's medication administration record.

E. The Designated Medication Staff will ensure that the pharmacy has the contact information for the program site and the main contact person who can answer questions and be the primary person responsible for coordinating refills.

Handling changes to prescriptions and implementation of those changes

A. All written instructions regarding changes to medications and treatments are required to be documented through a prescription label or the prescriber's written or electronically recorded order

for the prescription.

B. Changes made to prescriptions will be immediately communicated to the Designated Coordinator and/or Designated Manager and the assigned nurse or nurse consultant, as applicable.

C. Any concerns regarding these changes and the order will be resolved prior to administration of the medication to ensure safety and accuracy.

D. Staff will implement changes and document appropriately on the monthly medication sheet according to the above procedure in **Medication documentation and charting**.

E. Discontinued medications or medications that the dosage is no longer accurate due to the changes will be discarded appropriately.

Verification and monitoring of effectiveness of systems to ensure safe medication handling and administration (reporting and reviewing)

A. The designated person will be responsible for reviewing each person's medication administration record to ensure information is current and accurate. This will include a review of the monthly medication sheets, referrals, medication orders, etc.

B. At a minimum, this review will occur quarterly or more frequently if directed by the person and/or client representative or the ~~*Coordinated Service and*~~ *Support Plan* or ~~*Coordinated Service and*~~ *Support Plan Addendum*.

C. The designated person, on appropriate documentation, will also complete their review of medication supply and storage systems.

D. Written documentation of this review will be completed and will state if:
   1. Issues related to the safe and effective use of systems were noted.
   2. Concerns are present regarding medication orders, refusal to take or receive medications, or self-administration of medications.
   3. Medication is in correct supply and is being stored according to this policy.
   4. Information is current and accurate.
   5. Health care follow up regarding medication and treatment-related orders are being completed.

E. Based upon this quarterly or more frequent review, the designated person will notify the Designated Coordinator and/or Designated Manager, as needed, of any issues. Collaboratively, a plan must be developed and implemented to correct patterns of medication administration errors or systemic errors when identified. When needed, staff training will be included as part of this plan to correct identified errors.

F. The following information will be reported to the client representative and case manager as they occur or as directed by the *Coordinated Service and Support Plan* or *Coordinated Service and Support Plan Addendum:*
   1. Concerns about a person's self-administration of medication or treatment.
   2. A person's refusal or failure to take or receive medication or treatment as prescribed.
   3. Any reports made to the person's physician or prescriber regarding:
      a. If a dose of medication is not administered or treatment is not performed as prescribed, whether by staff error, the person's error, or by the person's refusal
      b. Occurrence of possible adverse reactions to the medication or treatment

Medication storage and security

A. The medication will be stored in an area/container that is inaccessible to the person served and will

be kept clean, dry, and within the appropriate temperature range.

B. Medication will not be left unattended or administered by a separate staff in lieu of the staff who prepared them for administration.

C. As possible each person served will have a separate container for their internal medications and a separate container for their external medications. External standing order medications will be in a separate container from internal standing order medications.

D. Medication will not be kept in the same area as food or chemicals (in the case of refrigerated medications, they will be kept in a locked container and separated from food).

E. All Schedule II Controlled Substances named in MN Statutes, section 152.02, subdivision 3, will be stored maintained, and disposed of in the following manner:
   1. These medications must be stored in a separate locked storage area within the locked medication area. Only staff and persons served authorized to administer the medication will have permitted access.
   2. The Designated Medication Staff will ensure that all Schedule II Controlled Substances are accounted for at least on a daily basis, or more frequently.
   3. Schedule II Controlled Substances as well as other medications needing to be destroyed or disposed of will be done according to the Environmental Protection Agency's recommendations.

IV. GENERAL AND SPECIFIC PROCEDURES ON ADMINISTRATION OF MEDICATION BY ROUTES

A. General procedures completed before administering medication **by any route**
   1. Staff must begin by washing their hands and assembling equipment necessary for administration.
   2. The person's monthly medication sheet is reviewed to determine what medications are to be administered and staff remove the medication from the storage area.
   3. Staff will compare the medication sheet with the label of each medication for the following:
      a. Right person
      b. Right medication
      c. Right date
      d. Right time
      e. Right route
      f. Right dose
      g. Expiration date
   4. If there is a discrepancy, the medication will not be administered. Instructions will be verified by contacting the assigned nurse, nurse consultant, pharmacist, or prescriber.
   5. Staff will compare the label with the medication sheet for the second time.
   6. Immediately prior to the administration of any medication or treatment, staff will identify the person and will explain to the person what is to be done.
   7. Staff will compare the label with the medication sheet for the third time before administering it, according to the specific procedures below, to the person.
   8. After administration, staff will document the administration of the medication or treatment or the reason for not administering the medication or treatment.
   9. Staff will contact the assigned nurse, nurse consultant, or prescriber regarding any concerns about the medication or treatment, including side effects, effectiveness, or a pattern of the person refusing to take the medication or treatment as prescribed.
   10. Adverse reactions will be immediately reported to the assigned nurse, nurse consultant, or prescriber.

B. Additional procedures for administration of **oral tablet/capsule/lozenge**
   1. If medications are in a bottle, staff will pour the correct number of tablets or capsules into the lid

of the medication container and transfer them to a medication cup.
2. If medications are in bubble packs, staff will, beginning with the highest number, push the correct dose into a medication cup, and write the date and their initials on the card next to the dose popped out.
3. If medication is in lozenge form, staff will unwrap the lozenge and transfer it to a medication cup.
4. Staff will administer the correct dosage by instructing the person to swallow the medication. If the medication is in lozenge form, staff will instruct the person not to chew or swallow the lozenge so it is able to dissolve in their mouth.
5. If the medication is to be swallowed (tablet/capsule), staff will offer at least 4 ounces of a beverage and remain with the person until the medication is swallowed.
6. If the medication is in lozenge form, staff will stay in the vicinity until the lozenge is completely dissolved; checking periodically to ensure the lozenge has not been chewed or swallowed.

C. Additional procedures for the administration of **liquid medications**
1. Staff will shake the medication if it is a suspension (staff will check the label if in doubt).
2. Staff will pour the correct amount of medication, at eye level on a level surface, with the label facing up, into a plastic medication measuring cup or measuring spoon.
3. Staff will wipe around the neck of the bottle with a damp paper towel, if sticky, and replace the cap.
4. Staff will dilute or dissolve the medication if indicated on the label or medication sheet with the correct amount of fluid.
5. Staff will administer the correct dose according to the directions in an appropriate container.
6. Staff will remain with the person until the medication is swallowed.

D. Additional procedures for the administration **of buccal medication**
1. Buccal medications are usually given in a liquid form and administered into the cheek.
2. Staff will open the container and measure the correct dose of liquid medication into a syringe or dropper.
3. Staff will position the person on their side.
4. Staff will administer the medication by squeezing the syringe or dropper into the person's cheek, with gloved hands, avoiding going between the teeth.
5. Staff will remain with the person to ensure that the medication has been absorbed into the cheek and that they have not drank any liquids.

E. Additional procedures for the administration of **inhaled medications**
1. If more than 1 inhaled medication is to be given, staff will state which one is administered first.
2. Staff will position the person sitting, if possible.
3. Staff will gently shake the spray container (Diskus style inhalers do not require shaking).
4. Staff will assemble the inhaler properly, if required, and remove the cover (Diskus style: staff will slide lever to open inhaler, then cock internal lever to insert dose into mouthpiece).
5. Staff will instruct the person to exhale through their mouth completely.
6. Staff will place the mouthpiece into the person's open mouth and instruct the person to close their lips around the mouthpiece.
7. Staff will press down the canister once, while instructing the person to inhale deeply and slowly through the mouth (Diskus style: staff will instruct the person to inhale the powdered medication).
8. Staff will wait 1 minute and repeat steps 5-7, if more than one puff is ordered.
9. Staff will instruct the person to rinse their mouth with water if directed.
10. Staff will return the medication to the locked area.
11. Staff will wash the inhaler mouthpiece daily with soap and warm water and dry it with a clean paper towel (Diskus style: staff will wipe the mouthpiece with a clean dry cloth).

F. Additional procedures for the administration of **nasal spray medications**

1. Staff will ask the person to blow their nose or will gently wipe the nose with gloved hands.
2. Staff will gently shake the spray container.
3. Staff will ask the person to tilt their head slightly forward.
4. Staff will remove the cap from the nozzle and will insert the nozzle into one nostril, aiming away from the septum (middle of the nostril).
5. Holding the other nostril closed, staff will instruct the person to inhale and squeeze once to spray.
6. Staff will repeat steps 4 and 5 to deliver the correct dosage to the other nostril.
7. Staff will rinse the nozzle with warm water, dry it with a clean paper towel, and replace the cap.

G. Additional procedures for the administration of **eye medications**
1. Staff will open the medication container.
2. Staff will position the person in a sitting or lying down position.
3. Staff will observe the eye(s) for any unusual conditions which should be reported to the nurse or prescriber prior to administration.
4. Staff will cleanse the eye (unless otherwise noted) with a clean tissue, gently wiping from the inner corner outward once (if medication is used in both eyes, staff will use a separate tissue for each eye).
5. Staff will assist or ask the person to tilt their head back and look up.
6. With gloved hands, staff will pull correct lower eyelid down to form a 'pocket' or ask the person to pull down their lower eyelid and will administer the correct dose (number of drops/strand for ointments) into the correct eye(s).
7. If different eye medications are prescribed, staff will five (5) minutes before administering the second medication.
8. Staff will avoid touching the tip of the dropper or tube to the person's eyelid or any other object or surface and replace the cap.
9. Staff will offer the person a tissue for each eye or blot the person's eye with separate tissues.

H. Additional procedures for the administration of **ear drop medication**
1. Staff will have the person sit or lie down with the affected ear up.
2. If sitting, staff will have the person tilt head sideways until the ear is as horizontal as possible.
3. If lying down, staff will have the person turn their head.
4. Staff will observe ears and notify the nurse or prescriber of any unusual condition prior to administration of the medication.
5. Staff will administer the correct number of drops, that are at room temperature, into the correct ear by pulling the ear gently backward and upward. For children, under 3 years of age, staff will pull the ear gently back and down.
6. Staff will have the person remain in the required position for one (1) to two (2) minutes.
7. Staff will have the person hold their head upright while holding a tissue against the ear to soak up any excess medication that may drain.
8. Staff will repeat the procedure for the other ear if necessary.
9. Staff will replace the cap on the container and will avoid touching the tip of the dropper to the person's ear or any other surface.

I. Additional procedures for the administration of **topical medications**
1. Staff will position the person as necessary for administration of the medication.
2. Staff will, prior to administering the medication, observe for any unusual conditions of the affected area of the body which should be reported to the nurse or prescriber.
3. Staff will wash and dry the affected area unless otherwise indicated.
4. Staff will administer medication to the correct area, according to directions, with the appropriate applicator or with gloved hands.
5. If the topical is in powder form, staff will instruct the person to avoid breathing particles in the air that may result from the application.

6. If the topical is a transdermal patch, staff will remove the old patch and select a new patch site (new patch should be applied to clean dry skin which is free of hair, cuts, sores, or irritation on upper torso unless otherwise directed).
7. If the topical is a transdermal patch, staff will unwrap the new patch, sign and date the patch, remove the backing, and apply it to the new patch site.
8. Staff will replace the cap on the container, if needed, avoiding contact with any other surfaces.

J. Staff will throw away all disposable supplies and place all medications in the locked medication storage area/container prior to leaving the area.

K. Staff will wash their hands.

This policy and procedure was established in consultation with and approved by:
Name: Shantele Gillmann
Title: Registered Nurse
Company: STAR Services
Date of consultation and final approval: June 28. 2022

Policy reviewed and authorized by:

_____

Print Name & Title Signature

Date of last policy review:_____ Date of last policy revision: _____

MRCI

Notice of Service Termination

Date [insert date of written notice]

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.

MRCI

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

MRCI

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

MRCI

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)

MRCI

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

MRCI

PROGRESS REPORT AND RECOMMENDATIONS

Name: Report Completed by (name and title): *Distribution Date:	Date of Progress Report: Type of Progress Report (i.e. annual): Date of service plan review meeting (if applicable):

*The report must be sent at least five working days prior to the progress review meeting if requested by the team in the ~~*CSSP or CSSP*~~ *Support Plan or Support Plan Addendum*.

To: ☐ Person Served ☐ Legal Representative ☐ Case Manager ☐ Other:

Summary of Service Outcome and Support Progress

Outcome #

Outcome statement with measurable and observable criteria for outcome achievement:

Summary of progress toward achieving this outcome:

Recommendation for implementing this outcome: ☐ Continue ☐ Change ☐ Discontinue

Rationale for the recommendation:

Summary of Service Outcome and Support Progress

Outcome #

Outcome statement with measurable and observable criteria for outcome achievement:

Summary of progress toward achieving this outcome:

Recommendation for implementing this outcome: ☐ Continue ☐ Change ☐ Discontinue

Rationale for the recommendation:

Summary of Service Outcome and Support Progress

Outcome #

Outcome statement with measurable and observable criteria for outcome achievement:

Summary of progress toward achieving this outcome:

Recommendation for implementing this outcome: ☐ Continue ☐ Change ☐ Discontinue

Rationale for the recommendation:

*Data collected on psychotropic medication and target symptom-related data including monitoring data, is sent to the expanded support team, at a minimum of quarterly, or as otherwise requested. This data is reported on *Psychotropic Medication Monitoring Data Report* form, please reference that document for more information.

Description of the person's status

Health:

What is currently important to the person and for the person:

Status of social relationships and natural supports:

Recent inclusion and participation in the community:

New or ongoing opportunities for the development and exercise of functional and age-appropriate skills, decision making and choice, personal advocacy, and communication:

Status of the person's civil and legal rights:

Other information as requested by the support team, please indicate:

SERVICE PLAN REVIEW MEETING AND ATTENDANCE NOTES

Name: Service plan review meeting date:

Time: Type of service plan review meeting (i.e. annual): Annual

Location of meeting:

Persons attending:

Name	Relationship	Agency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

The purpose of this meeting is to provide an opportunity for support team or expanded support team members to participate in the ongoing review and development of the service plan and the methods used to support the person and accomplish outcomes. This meeting is also intended to determine whether changes are needed to the service plan based on the assessment information, the license holder's evaluation of progress towards accomplishing outcomes, or other information provided by the team.

A review of the person's service and support outcomes occurred and the following determinations regarding those outcomes were made:

Changes needed to the ~~*Coordinated Service and*~~ *Support Plan Addendum, Self-Management Assessment,* or other document in the service plan, include, if any:

Annual notification of procedural revisions to policies not affecting service recipient rights, with copies provided if requested, occurred. ☐ Yes ☐ No ☐ NA-no policies were revised during this past annual year

State what policies were revised that required notification:

Other meeting discussion notes:

MRCI

POLICY AND PROCEDURE ON REVIEWING INCIDENTS AND EMERGENCIES

Program name: _____

I. PURPOSE

The purpose of this policy is to establish guidelines for the internal review of incidents and emergencies.

II. POLICY

MRCI is committed to the prevention of and safe and timely response to incidents and emergencies. Staff will act immediately to respond to incidents and emergencies as directed in the *Policy and Procedure on Responding to and Reporting Incidents* and the *Policy and Procedure on Emergencies.* After the health and safety of person(s) served are ensured, staff will complete all required documentation that will be compiled and used as part of the internal review process.

MRCI will ensure timely completion of the internal review procedure of incident and emergencies to identify trends or patterns and corrective action, if needed.

III. PROCEDURE

A. The Designated Manager will conduct a review of all reports of incidents and emergencies for identification of patterns and implementation of corrective action as necessary to reduce occurrences. This review will include:
   1. Accurate and complete documentation standards that include the use of objective language, a thorough narrative of events, appropriate response, etc.
   2. Identification of patterns which may be based upon the person served, staff involved, location of incident, etc. or a combination.
   3. Corrective action that will be determined by the results of the review and may include, but is not limited to, retraining of staff, changes in the physical plant of the program site, and/or changes in the ~~*Coordinated Service and*~~ *Support Plan Addendum.*

B. Each *Incident and Emergency Report* will contain the following information:
   1. The name of the person or persons involved in the incident. It is not necessary for staff to identify all persons affected by or involved in an emergency unless the emergency resulted in an incident.
   2. The date, time, and location of the incident or emergency.
   3. A description of the incident or emergency.
   4. A description of the response to the incident or emergency and whether a person's ~~*Coordinated Service and*~~ *Support Plan Addendum* or program policies and procedures were implemented as applicable.
   5. The name of the staff person or persons who responded to the incident or emergency.
   6. The determination of whether corrective action is necessary based on the results of the review that will be completed by the Designated Manager.

C. In addition to the review for the identification of patterns and implementation of corrective action, MRCI will consider the following situations reportable as incidents or emergencies which will require the completion of an internal review:
   1. Emergency use of manual restraint as defined in MN Statutes, sections 245D.02, subdivision 8a and 245D.061. MN Statutes, section 245D.061, subdivision 6, has an internal review report requiring the answering of six questions.
   2. Death and serious injuries not reported as maltreatment according to MN Statutes, section 245D.06, subdivision 1, paragraph g.
   3. Reports of maltreatment of vulnerable adults or minors according to MN Statutes, sections 626.557 and ~~626.556~~ 260E.
   4. Complaints or grievances as defined in MN Statutes, section 245D.10, subdivision 2.

D. When MRCI has knowledge that a situation has occurred that requires an internal review, the Designated Manager will ensure that an *Incident and Emergency Report* or *Emergency Use of Manual Restraint Incident Report* has been completed.
   1. In addition to the *Incident and Emergency Report*, if there was a death or serious injury, the Designated Manager will also ensure that the applicable documents have also been completed for the MN Office of the Ombudsman for Mental Health and Developmental Disabilities and the Department of Human Services Licensing Division.
   2. For internal reports of suspected or alleged maltreatment of a vulnerable adult, a copy of the *Notification to an Internal Reporter* will also be submitted for the internal review.
   3. The internal review and reporting of emergency use of manual restraints will be completed according to the *Policy and Procedure on Emergency Use of Manual Restraint.*

E. Documentation to be submitted to the designated person responsible for completing internal reviews will include, as applicable:
   1. *Incident and Emergency Report.*
   2. *Notification to an Internal Reporter.*
   3. *Emergency Use of Manual Restraint Incident Report.*
   4. *Death Reporting Form.*
   5. *Serious Injury Form.*
   6. *Death or Serious Injury Report FAX Transmission Cover Sheet.*
   7. *Complaint Summary and Resolution Notice.*

F. The Client Directed Services Licensing Coordinator is the primary individual responsible for ensuring that internal reviews are completed for reports. If there are reasons to believe that the Client Directed Services Licensing Coordinator is involved in the alleged or suspected maltreatment or is unable to complete the internal review, the Vice President, Client Directed Services is the secondary individual responsible for ensuring that internal reviews are completed.

G. The internal review will be completed (within 30 days for Maltreatment reports) using the *Internal Review* form and will include an evaluation of whether:
   1. Related policies and procedures were followed.
   2. The policies and procedures were adequate.
   3. There is a need for additional staff training.
   4. The reported event is similar to past events with the persons or the services involved.
   5. There is a need for corrective action by the license holder to protect the health and safety of persons served.

H. Based upon the results of the review, the license holder will develop, document, and implement a corrective action plan designed to correct current lapses and prevent future lapses in performance by staff or the license holder, if any.

I. The following information will be maintained in the service recipient record, as applicable:
   1. *Incident and Emergency Report* including the written summary and the Designated Manager's review.
   2. *Emergency Use of Manual Restraint Incident Report* and applicable reporting and reviewing documentation requirements.
   3. *Death Reporting Form.*

4. *Serious Injury Form.*
5. *Death or Serious Injury Report FAX Transmission Cover Sheet.*
6. *Complaint Summary and Resolution Notice*.

J. Completed *Internal Reviews* and documentation regarding suspected or alleged maltreatment will be maintained separately by the internal reviewer in a designated file that is kept locked and only accessible to authorized individuals.

K. Internal reviews must be made accessible to the commissioner immediately upon the commissioner's request for internal reviews regarding maltreatment.

Policy reviewed and authorized by:

_____

Print name & title Signature

Date of last policy review: _____ Date of last policy revision: _____

MRCI

RIGHTS RESTRICTION

Name: Date:

Restriction of a person's rights is allowed only if determined necessary to ensure the health, safety, and well-being of the person. Any restriction of these rights (245D.04, subd. 3, para. a, clauses 13-15 or para. b, clauses 1-4) must be documented in the ~~*Coordinated Service and*~~ *Support Plan* and/or ~~*Coordinated Service and*~~ *Support Plan Addendum* for the person. The restriction must be implemented in the least restrictive alternative manner necessary to protect the person and provide support to reduce or eliminate the need for the restriction in the most integrated setting and inclusive manner. The documentation must include the following information:

1. Right(s) to be restricted:

2. Justification for the restriction based on an assessment of the person's vulnerability related to exercising the right without restriction:

3. Objective measures set as conditions for ending the restriction:

4. Schedule for reviewing the need for the restriction based on the conditions for ending the restriction to occur semiannually from the date of initial approval, at a minimum, or more frequently if requested by the person and/or legal representative and case manager:

I understand that this restriction may only be implemented upon signed and dated approval. ☐ Yes ☐ No

I understand that I may withdraw this approval at any time. ☐ Yes ☐ No

I understand that if approval is withdrawn, the right(s) must be immediately and fully restored. ☐ Yes ☐ No

Date of approval of this rights restriction:

_____ _____

Person served and/or legal representative Case manager

Safe Transportation

Program Name: _____

PURPOSE

The purpose of this policy is to ensure the safety of persons served as well as employees during transportation and include the provisions for handling emergency situations.

POLICY

When transportation is the responsibility of MRCI WorkSource, employees will assist in transporting, handling, and transferring persons served in a safe manner and according to their ~~*Community Service and*~~ *Support Plan* and/or ~~*Community Service and*~~ *Support Plan Addendum.*

PROCEDURE

A. Employees are prohibited by state law (MN Statutes, section 169.475) to compose, send, or receive an electronic message while operating a motor vehicle. This includes a program vehicle or an employee's own vehicle. An electronic message (as defined by state law) "means a self-contained piece of digital communication that is designed or intended to be transmitted between physical devices. An electronic message includes, but is not limited to, e-mail, a text message, an instant message, a command or request to access a World Wide Web page, or other data that uses a commonly recognized electronic communications protocol. An electronic message does not include voice or other data transmitted as a result of making a phone call, or data transmitted automatically by a wireless communications device without direct initiation by a person."

B. Employees will receive training on each person's transferring or handling requirements for the person and/or equipment prior to transferring or transporting persons. All transfers and handling of persons served will be done in a manner that ensures their dignity and privacy. Any concerns regarding transportation, transfers, and handling will be promptly communicated to the Managing Party who will address these concerns. This will be done immediately if the health and safety of the person(s) served are at risk.

C. When equipment used by a person served is needed, employees will place the equipment in a safe location in the vehicle such as the trunk of a car. If a program vehicle does not have a designated storage space such as a trunk, employees will place the equipment in an area of the vehicle and secure it, when possible, so that there is limited to no shifting during transport.

D. If there is an emergency while driving, employees follow emergency response procedures to ensure the person(s) safety. This will include pulling the vehicle over and stopping in a safe area as quickly and as safely as possible. Employees will use a cell phone or any available community resource to contact "911" for help if needed. If a medical emergency were to occur, employees will call "911" and follow first aid and/or CPR protocols according to their training.

E. While transporting more than one person served and person to person physical

aggression occurs, employees will pull over and stop the vehicle in a safe area as quickly and as safely as possible, redirect the persons served. If necessary, call“911” for assistance.

F. Upon employment, employees are informed of the requirement that they must hold a valid driver’s license, appropriate insurance, and maintain a safe driving record. Employees may also be required to complete additional training on safe transportation procedures.

G. When dropping off persons served at a site which requires a change in employees, transporting employees will ensure that a responsible party is present before leaving the person served unless otherwise specified in the person’s ~~*Community Service and*~~ *Support Plan* and/or ~~*Community Service and*~~ *Support Plan Addendum.* Any necessary information will be presented to the employees or other responsible party.

H. In accordance with state laws, anyone riding in a moving vehicle must wear seatbelts and/or child safety restraints.

Policy reviewed and authorized by:

_____

Print name & title Signature

Date of last policy review: _____ Date of last policy revision:_____

SELF-MANAGEMENT ASSESSMENT

Name:

Date of *Self-Management Assessment* development: For the annual period from: to

Name and title of person completing the review:

Within the scope of services to this person, the license holder must assess, at a minimum, the areas included on this document. Additional information on self-management may be included per request of the person served and/or legal representative and case manager. The *Self-Management Assessment* will be completed by the company's designated staff person and will be done in consultation with the person and members of the support team.

The license holder will complete this assessment before the 45-day planning meeting and review it at the meeting. Within 20 working days of the 45-day meeting, dated signatures will be obtained from the person and/or legal representative and case manager to document the completion and approval of the *Self-Management Assessment.* At a minimum of annually, or within 30 days of a written request from the person and/or legal representative or case manager. This *Self-Management Assessment* will be reviewed by the support team or expanded support team as part of a service plan review and dated signatures obtained.

Assessments must be based on the person's status within the last 12 months at the time of service initiation. Assessments based on older information must be documented and justified.

The **general and health-specific supports and outcomes necessary or desired to support the person** based upon this assessment and the requirements of person centered planning and service delivery will be documented in the ~~*CSSP*~~ *Support Plan Addendum.*

Health and medical needs to maintain or improve physical, mental, and emotional well-being

Assessment area	**Is the person able to self-manage in this area?**	**Assessment – include information about the person that is descriptive of their overall strengths, functional skills and abilities, and behaviors or symptoms**
Allergies (state specific allergies):	☐ Yes ☐ No ☐ NA – there are no allergies	
Seizures (state specific seizure types):	☐ Yes ☐ No ☐ NA – no seizures	
Choking	☐ Yes ☐ No	

Special dietary needs (state specific need):	☐ Yes ☐ No ☐ NA – there are no special dietary needs	
Chronic medical conditions (state condition):	☐ Yes ☐ No ☐ NA – there are no chronic medical conditions	
Self-administration of medication or treatment orders	☐ Yes ☐ No	
Preventative screening	☐ Yes ☐ No	
Medical and dental appointments	☐ Yes ☐ No	
Other health and medical needs (state specific need):	☐ Yes ☐ No ☐ NA	
Other health and medical needs (state specific need):	☐ Yes ☐ No ☐ NA	
Other health and medical needs (state specific need):	☐ Yes ☐ No ☐ NA	

Personal safety to avoid injury or accident in the service setting

Assessment area	**Is the person able to self-manage in this area?**	**Assessment – include information about the person that is descriptive of their overall strengths, functional skills and abilities, and behaviors or symptoms**
Risk of falling (include the specific risk):	☐ Yes ☐ No ☐ NA – not at risk for falling	
Mobility issues (include the specific issue):	☐ Yes ☐ No ☐ NA – there are no mobility issues	
Regulating water temperature	☐ Yes ☐ No	

Community survival skills	☐ Yes ☐ No	
Water safety skills	☐ Yes ☐ No	
Sensory disabilities	☐ Yes ☐ No ☐ NA	
Other personal safety needs (state specific need):	☐ Yes ☐ No ☐ NA	
Other personal safety needs (state specific need):	☐ Yes ☐ No ☐ NA	
Other personal safety needs (state specific need):	☐ Yes ☐ No ☐ NA	

Symptoms or behavior that may otherwise result in an incident as defined in section 245D.02, subd. 11 clauses (4) to (7) or suspension or termination of services by the license holder, or other symptoms or behaviors that may jeopardize the health and safety of the person or others.

Assessment area	**Is the person able to self-manage in this area?**	**Assessment – include information about the person that is descriptive of their overall strengths, functional skills and abilities, and behaviors or symptoms**
Self-injurious behaviors (state behavior):	☐ Yes ☐ No ☐ NA	
Physical aggression/conduct (state behavior):	☐ Yes ☐ No ☐ NA	
Verbal/emotional aggression (state behavior):	☐ Yes ☐ No ☐ NA	
Property destruction (state behavior):	☐ Yes ☐ No ☐ NA	
Suicidal ideations, thoughts, or attempts	☐ Yes ☐ No ☐ NA	
Criminal or unlawful behavior	☐ Yes ☐ No ☐ NA	

Mental or emotional health symptoms and crises (state diagnosis):	☐ Yes ☐ No ☐ NA	
Unauthorized or unexplained absence from a program	☐ Yes ☐ No ☐ NA	
An act or situation involving a person that requires the program to call 911, law enforcement or fire department	☐ Yes ☐ No ☐ NA	
Other symptom or behavior (be specific):	☐ Yes ☐ No ☐ NA	

SIGNATURE PAGE

By signing below, I am indicating the completion and approval of the *Self-Management Assessment*.

Person served:	Date:
Legal representative:	Date:
Case manager:	Date:
Licensed provider contact:	Date:
Other support team member (name and title):	Date:
Other support team member (name and title):	Date:

Please note:
Within 20 working days of the 45-day planning meeting (and within 10 working days of the service plan review meeting), the assessment and this addendum must be submitted to and dated signatures obtained dated by the person served and/or legal representative and case manager to document completion and approval. If within 10 working days of this submission, the person served and/or legal representative or case manager has not signed and returned to the license holder the assessment and ~~*Coordinated Service and*~~ *Support Plan Addendum* or has not proposed written modification to its submission, the submission is deemed approved and in effect. It will remain in effect until the next annual month or until the person served and/or legal representative or case manager submits a written request to revise them.

Service Recipient Record Checklist

Person name: _____

Program name: _____

This is checklist is used to review and verify that the service recipient record is maintained according to the licensing requirements in Minnesota Statutes, section 245D.095.

- The program must maintain a record of current services provided to each person on the premises where the services are provided or coordinated. When the services are provided in a licensed facility, the records must be maintained at the facility; otherwise the records must be maintained at the license holder's program office.
- The program must protect service recipient records against loss, tampering, or unauthorized disclosure.
- The program must ensure that the following people have access to the information in accordance with applicable state and federal laws, regulations, or rules:
  (1) the person, the person's legal representative, and anyone properly authorized by the person;
  (2) the person's case manager;
  (3) staff providing services to the person unless the information is not relevant to carrying out the coordinated service and support plan or coordinated service and support plan addendum;
  (4) the county child or adult foster care licensor, when services are also licensed as child or adult foster care; and
  (5) the DHS licensor or investigator as required under the Human Services Licensing Act, Minnesota Statutes, Chapter 245A.

Required Documentation Completed in Service Recipient Record	**Staff Initials**
1. Admission form signed by the person or legal representative that includes: a. the person's legal name, date of birth, address, and telephone number; and b. the name, address and telephone number of the person's legal representative, primary contact, case manager, family members, or other people identified by the person.	
2. Service information, including: a. service initiation information b. verification of the person's eligibility for services c. documentation verifying that services have been provided as identified in the ~~CSSP~~ Support Plan or ~~CSSP~~ Support Plan addendum d. date of admission or readmission	
3. Health information, including medical history, special dietary needs, and allergies.	
4. When the program is assigned responsibility for meeting the person's health service needs, documentation of:	
a. current orders for medications, treatments, or medical equipment;	
b. signed authorization from the person or the person's legal representative to	

administer or assist in administering the medication or treatments;	
c. signed statement authorizing the program to act in a medical emergency when the person's legal representative cannot be reached or delayed in arriving;	
d. medication administration procedures for the individual person;	
e. medication administration record that documents implementation of medication administration procedures, and medication administration record reviews, including any agreements for administration of injectable medications by the program; and	
f. medical appointment schedule.	
5. A copy of the person's current coordinated service and support plan or the portion assigned to the program.	
6. A copy of the individual abuse prevention plan.	
7. Copies of service planning assessments required under section 245D.071, subdivisions 2 and 3	
8. A record of other service providers, including: contact person, telephone number, services being provided, and names of staff responsible for coordination of services.	
9. Documentation of orientation to service recipient rights and maltreatment reporting policies and procedures.	
10. Copies of authorizations to handle a person's funds.	
11. Documentation of complaints received and grievance resolutions.	
12. When requested by the person, legal representative, case manager or team: copies of written reports regarding the person including: progress review reports, progress or daily log notes recorded by the program, and reports received from other agencies involved in providing services or care of the person.	
13. Discharge summary.	
14. Service suspension/termination and related documentation, if applicable.	

MRCI

Service Recipient Rights

Person name: _____

Program name: _____

This packet contains information regarding your rights while receiving services and supports from this program, information on restriction of your rights, and information of where you can go if you have questions or need additional information related to your rights.

☐ I received the following information within five working days of when I started to receive services and every year after that.

1. A copy of my rights under the law, Minnesota Statutes, section 245D.04.
2. An explanation of what my rights are and that I am free to exercise my rights; and that this program must help me exercise my rights and help protect my rights.

Date services were started: _____ Date I received this information: _____

☐ This information was provided to me in a way that I understand. If I needed the information in another format or language, it was given to me in that format or language.

☐ If my rights are or will be restricted in any way to protect my health, safety, and well-being, the restriction has been explained to me and I understand the program must document and implement the restriction as required by law to make sure I get my rights back as soon as possible.

Are there any restrictions placed on my rights? ☐ Yes (if yes, see rights restriction document) ☐ No

☐ I understand that I may contact the agencies below if I need help to exercise or protect my rights:

Office of the Ombudsman for Mental Health
and Developmental Disabilities
121 7th Place E, Suite 420
Metro Square Building
St. Paul, MN 55101
Phone: (651) 7567-1800 or 1(800) 657-3506
Fax: (651) 797-1950
Website: www.ombudmhdd.state.mn.us

Minnesota Disability Law Center
430 1st Ave N, Suite 300
Minneapolis, MN 55401
Email: mndlc@mylegalaid.org
Website: http://www.mndlc.org/

☐ I want _____ to help me exercise my rights. The program has this person's contact information in my record.

By signing this document I am agreeing that I have read and understand the boxes I checked above.

_____

Person/Legal representative Date

SERVICE RECIPIENT RIGHTS

Program name: _____

This program is licensed under Minnesota Statutes, Chapter 245D. It must help you exercise and protect your rights identified in Minnesota Statutes, section 245D.04.

When receiving services and supports from this program name, I have the right to:

1. Take part in planning and evaluating the services that will be provided to me.
2. Have services and supports provided to me in way that respects me and considers my preferences (including personal items in my bedroom).
3. Refuse or stop services and be informed about what will happen if I refuse or stop services.
4. Know, before I start to receive services from this program, if the program has the skills and ability to meet my need for services and supports.
5. Know the conditions and terms governing the provision of services, including the program's admission criteria and policies and procedures related to temporary service suspension and service termination.
6. Have the program help coordinate my care if I transfer to another provider to ensure continuity of care.
7. Know what services this program provides and how much they cost, regardless of who will be paying for the services, and to be notified if those charges changes.
8. Know, before I start to receive services, if the cost of my care will be paid for by insurance, government funding, or other sources, and be told of any charges I may have to pay.
9. To have staff that is trained and qualified to meet my needs and support.
10. Have my personal, financial, service, health, and medical information kept private and be notified if these records have been shared.
11. Have access to my records and recorded information that the program has about me as allowed by state and federal law, regulation, or rule

12. Be free from abuse, neglect or financial exploitation by the program or its staff.

13. Be free from staff trying to control my behavior by physically holding me or using a restraint to keep me from moving, giving me medication I don't want to take or that isn't prescribed for me, or putting me in time out or seclusion; except if and when manual restraint is needed in an emergency to protect me or others from physical harm.

14. Receive services in a clean and safe location.

15. Be treated with courtesy ~~and respect and have my property treated with respect ,~~ have access to and respectful treatment of my personal property.

16. Be allowed to reasonably follow my cultural and ethnic practices and religion.

17. Be free from prejudice and harassment regarding my race, gender, age, disability, spirituality, and sexual orientation.

18. Be told about and to use the program's grievance policy and procedures, including knowing how to contact persons responsible for helping me to get my problems with the program fixed and how to file a social services appeal under the law.

19. Know the names, addresses and phone numbers of people who can help me, including the ombudsman, and to be given information about how to file a complaint with these offices.

20. Exercise my rights on my own or have a family member or another person help me exercise my rights, without retaliation from the program.

21. Give or not give written informed consent to take part in any research or experimental treatment.

22. Choose my own friends and spend time with them at home or in the community.

23. Have personal privacy, including the right to use a lock on my bedroom door.

24. Take part in activities that I choose.

25. Have access to my personal possessions at any time, including financial resources.

RESIDENTIAL SERVICES AND SUPPORTS (meaning out-of-home crisis respite, supported living services, foster care services in a foster care home or a community residential setting) MUST INCLUDE THESE ADDITIONAL RIGHTS:

26. Have free, daily, private access to and use of a telephone for local calls, and long-distance calls made collect or paid for by me.

27. Receive and send mail and emails and not have them opened by anyone else unless I ask.

28. Use of and have free access to common areas (this includes the kitchen).(this includes access to food at any time) and the freedom to come and go at will.

29. ~~Visit alone with my spouse, family, legal counsel, religious guide, or others allowed in Minnesota Human Services Rights Act, Minnesota Statutes, section 363A.09, including my bedroom.~~ Choose who visits, when they visit and to have visits in private (including bedroom) with my spouse, family, legal counsel, religious guide, or others allowed in Minnesota Human Services Rights Act, Minnesota Statutes, section 363A.09.

30. Have access to three nutritious meals, nutritious snacks between meals each day, and access to food and water at any time.

31. Choose how to furnish and decorate my bedroom or living unit.

32. A home that is clean, safe, and meets the requirements of a dwelling unit as defined in state fire code.

RIGHTS RESTRICTIONS

CAN MY RIGHTS BE RESTRICTED?

Restriction of your rights is allowed only if determined necessary to ensure your health, safety, and well-being. Any restriction of your rights must be documented in your coordinated service and support plan or coordinated service and support plan addendum. The restriction must be implemented in the least restrictive alternative manner necessary to protect you and provide you support to reduce or eliminate the need for the restriction in the most integrated setting and inclusive manner.

WHAT IS THE PROGRAM REQUIRED TO DO IF MY RIGHTS WILL BE RESTRICTED?

Before this program may restrict your rights in way this program must document the following information:

1. the justification (meaning the reason) for the restriction based on an assessment of what makes you vulnerable to harm or maltreatment if you were allowed to exercise the right without a restriction;
2. the objective measures set as conditions for ending the restriction (meaning the program must clearly identify when everyone will know the restriction is no longer needed and it has to end);
3. a schedule for reviewing the need for the restriction based on the conditions for ending the restriction to occur semiannually from the date of initial approval, at a minimum, or more frequently if requested by the person, the person's legal representative, if any, and case manager (meaning that at least every six months, more often if you want, the program must review with you and your authorized representative or legal representative and case manager, why the restriction is still needed and how the restriction should change to allow you as much freedom as possible to exercise the right being restricted); and
4. signed and dated approval for the restriction from you or your legal representative, if any.

CAN THE PROGRAM RESTRICT ALL OF MY RIGHTS?

The program cannot restrict any right they chose. The only rights the program may restrict, after documenting the need, include:

1. Your right to associate with other persons of your choice;
2. Your right to have personal privacy; and
3. Your right to engage in activities that you choose.
4. Your right to access your personal possessions at any time.

[LICENSE HOLDERS PROVIDING RESIDENTIAL SUPPORTS AND SERVICES MUST INCLUDE THESE ADDITIONAL RESTRICTIONS IN THIS LIST]

5. Your right to have daily, private access to and use of a non-coin-operated telephone for local calls and long-distance calls made collect or paid for by the person;
6. Your right to receive and send, without interference, uncensored, unopened mail or electronic correspondence or communication; and
7. Your right to have use of and free access to common areas in the residence; and
8. Your right to privacy for visits with the person's spouse, next of kin, legal counsel, religious advisor, or others, in accordance with section 363A.09 of the Human Rights Act, including privacy in the person's bedroom.

9. Your right to choose how to furnish and decorate your bedroom or living unit.

WHAT IF I DON'T GIVE MY APPROVAL?

A restriction of your rights may be implemented only after you have given your approval.

WHAT IF I WANT TO END MY APPROVAL?

You may withdraw your approval of the restriction of your right at any time. If you do withdraw your approval, the right must be immediately and fully restored.

MRCI

POLICY AND PROCEDURE ON SERVICE TERMINATION

I. PURPOSE

The purpose of this policy is to establish determination guidelines and notification procedures for service termination.

II. POLICY

It is the intent of MRCI to ensure continuity of care and service coordination between members of the support team including, but not limited to the person served, the legal representative and/or designated emergency contact, case manager, other licensed caregivers, and other people identified by the person and/or legal representative during situations that may require or result in service termination. MRCI restricts service termination to specific situations according to MN Statutes, section 245D.10, subdivision 3a.

III. PROCEDURE

MRCI recognizes that *temporary service suspension* and *service termination* are two separate procedures. MRCI must limit temporary service suspension to specific situations that are listed in the *Policy and Procedure on Temporary Service Suspension*. A temporary service suspension may lead to or include service termination or MRCI may do a temporary service suspension by itself. MRCI must limit service termination to specific situations that are listed below. A service termination may include a temporary service suspension or MRCI can do a service termination by itself.

A. MRCI must permit each person served to remain in the program or continue receiving services and must not terminate services unless:
   1. The termination is necessary for the person's welfare and the ~~facility~~ license holder cannot meet the person's needs;
   2. The safety of the person, ~~or~~ others in the program, or staff is endangered and positive support strategies were attempted and have not achieved and effectively maintained safety for the person or others;
   3. The health of the person, ~~or~~ others in the program, or staff would otherwise be endangered;
   4. The ~~program~~ license holder has not been paid for services;
   5. The ~~program~~ license holder ceases to operate; or
   6. The person has been terminated by the lead agency from waiver eligibility.

B. Prior to giving notice of service termination, MRCI must document actions taken to minimize or eliminate the need for termination. Action taken by MRCI must include, at a minimum:
   1. Consultation with the person's expanded/support team to identify and resolve issues leading to issuance of the termination notice; and
   2. A request to the case manager for intervention services as identified in section 245D.03, subdivision 1, paragraph (c), clause (1), or other professional consultation or intervention services to support the person in the program. This requirement does not apply to notices of service termination issued due to the program not being paid for services.
   3. If, based on the best interests of the person, the circumstances at the time of the termination notice were such that MRCI was unable to take the action specified above, MRCI must document the specific circumstances and the reason for being unable to do so.

C. The notice of service termination must meet the following requirements:
   1. MRCI must notify the person or the person's legal representative and the case manager in writing of the intended services termination; and
   2. The notice must include:
      a. The reason for the action;

b. Except for a service termination when the program ceases to operate, a summary of actions taken to minimize or eliminate the need for service termination or temporary service suspension as required under section 245D.10, subdivision 3a, paragraph (c), and why these measures failed to prevent the termination or suspension;
c. The person's right to appeal the termination of services under MN Statutes, section 256.045, subdivision 3, paragraph (a); and
d. The person's right to seek a temporary order staying the termination of services according to the procedures in MN Statutes, section 256.045, subdivision 4a or 6, paragraph (c).

D. Notice of the proposed termination of service, including those situations that began with a temporary service suspension, must be given:
1. At least 60 days prior to termination when MRCI is providing intensive supports and services identified in section 245D.03, subdivision 1, paragraph (c).
2. At least 30 days prior to termination for all other services licensed under Chapter 245D.
3. This termination notice may be given in conjunction with a notice of temporary services suspension.

E. During the service termination notice period, MRCI must:
1. Work with the expanded/support team to develop reasonable alternative to protect the person and others and to support continuity of care;
2. Provide information requested by the person or case manager; and
3. Maintain information about the service termination, including the written notice of intended service termination, in the service recipient record.

Policy reviewed and authorized by:

_____

Print name & title Signature

Date of last policy review: _____ Date of last policy revision: _____

Legal Authority: MS §§ 245D.11, subd. 4; 245D.04, subd.2,(4) to (7), and 3, (8)

POLICY AND PROCEDURE ON REPORTING AND REVIEW OF MALTREATMENT OF VULNERABLE ADULTS

I. PURPOSE

The purpose of this policy is to establish guidelines for the external and internal reporting and the internal review of maltreatment of vulnerable adults.

II. POLICY

Staff who are mandated reporters must report all of the information they know regarding an incident of known or suspected maltreatment, either externally or internally, in order to meet their reporting requirements under law. All staff of MRCI who encounter maltreatment of a vulnerable adult will take immediate action to ensure the safety of the person(s) served. Staff will define maltreatment of vulnerable adults as abuse, neglect, or financial exploitation and will refer to the definitions from Minnesota Statutes, section 626.5572 at the end of this policy.

Employees will refer to the *Policy and Procedure on Reporting and Review of Maltreatment of Minors* regarding suspected or alleged maltreatment of persons 17 years of age or younger.

III. PROCEDURE

A. Staff of MRCI who encounter maltreatment of a vulnerable adult, age 18 or older, will take immediate action to ensure the safety of the person or persons. If a staff knows or suspects that a vulnerable adult is in immediate danger, they will call “911.”

B. If a staff knows or suspects that maltreatment of a vulnerable adult has occurred, they must make a verbal report immediately (within 24 hours) either to the Common Entry Point (CEP) or internally to MRCI. Should the staff choose to make a report directly to an external agency, they must make the verbal report by calling the Common Entry Point.

The phone number for the Common Entry Point is: 1-844-880-1574
Website: mn.gov/dhs/reportadultabuse/

C. Kinzie Matthies, *Program Coordinator* is the primary individual responsible for receiving internal reports of maltreatment and for forwarding internal reports to the Common Entry Point. If there are reasons to believe that the Kinzie Matthies is involved in the alleged or suspected maltreatment, Julie Lux, *Designated Manager* is the secondary individual responsible for receiving internal reports of maltreatment and for forwarding internal reports to the Common Entry Point.

1. Kinzie Matthies, 245D Program Coordinator
   Phone: 507-386-5678
   Email: kmatthies@mymrci.org
   Toll Free Number: 800-829-7110

2. Julie Lux, Designated Manager
   Phone: 507-386-5745
   Email: jlux@mymrci.org
   Toll Free Number: 800-829-7110

D. When verbally reporting the alleged or suspected maltreatment, either externally or internally, staff will include as much information as known and will cooperate with any subsequent investigation.

E. For internal reports of suspected or alleged maltreatment, the person who received the report will:
   1. Contact the Common Entry Point if the report is determined to be suspected or alleged maltreatment.

   2. Inform the case manager within 24 hours of reporting maltreatment, unless there is reason to believe that the case manager is involved in the suspected maltreatment. The person who received the report will disclose to the case manager the:
      a. Nature of the activity or occurrence reported
      b. The agency that received the report

   3. Complete and mail the *Notification to an Internal Reporter* to the home address of the staff who reported the maltreatment within two working days in a manner that protects the reporter's confidentiality. The notification must indicate whether or not MRCI reported externally to the Common Entry Point. The notice must also inform the staff that if MRCI did not report externally and they are not satisfied with that determination, they may still make the external report to the Common Entry Point themselves. It will also inform the staff that they are protected against any retaliation if they decide to make a good faith report to the Common Entry Point on their own.

F. When MRCI has knowledge that an external or internal report of alleged or suspected maltreatment has been made, an internal review will be completed. The *Designated Coordinator or Designated Manager* is the primary individual responsible for ensuring that internal reviews are completed for reports of maltreatment. If there are reasons to believe that the *Designated Coordinator* is involved in the alleged or suspected maltreatment, the *Designated Manager* is the secondary individual responsible for ensuring that internal reviews are completed.

G. The *Internal Review* will be completed within 30 calendar days. The internal MRCI staff person will:
   1. Ensure an *Incident and Emergency Report* has been completed.
   2. Contact the lead investigative agency if additional information has been gathered.
   3. Coordinate any investigative efforts with the lead investigative agency by serving as MRCI contact, ensuring that staff cooperate, and that all records are available.
   4. Complete an *Internal Review* which will include the following evaluations of whether:
      a. Related policies and procedures were followed
      b. The policies and procedures were adequate
      c. There is a need for additional staff training
      d. The reported event is similar to past events with the vulnerable adults or the services involved
      e. There is a need for corrective action by the license holder to protect the health and safety of the vulnerable adult(s)
   5. Complete the *Alleged Maltreatment Review Checklist* and compile together all documents regarding the report of maltreatment.

H. Based upon the results of the internal review, MRCI will develop, document, and implement a corrective action plan designed to correct current lapses and prevent future lapses in performance by individuals or MRCI, if any.

I. Internal reviews must be made accessible to the commissioner immediately upon the commissioner's request for internal reviews regarding maltreatment.

J. MRCI will provide an orientation to the internal and external reporting procedures to all persons served and/or legal representatives. This orientation will include the telephone number for the Common Entry Point. This orientation for each new person to be served will occur within 24 hours of admission, or for persons who would benefit more from a later orientation, the orientation may take place within 72 hours.

K. Staff will receive training on this policy, MN Statutes, section 245A.65 and sections 626.557 and 626.5572 and their responsibilities related to protecting persons served from maltreatment and reporting maltreatment. This training must be provided within 72 hours of first providing direct contact services and annually thereafter.

DEPARTMENT OF HUMAN SERVICES LICENSING DIVISION: 651-431-6500

MINNESOTA STATUTES, SECTION 626.5572 DEFINITIONS

Subdivision 1.**Scope.**
For the purpose of section 626.557, the following terms have the meanings given them, unless otherwise specified.

Subd. 15.**Maltreatment.**
"Maltreatment" means abuse as defined in subdivision 2, neglect as defined in subdivision 17, or financial exploitation as defined in subdivision 9.

Subd. 2.**Abuse.**
"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;
(2) the use of drugs to injure or facilitate crime as defined in section 609.235;
(3) the solicitation, inducement, and promotion of prostitution as defined in section 609.322; and
(4) criminal sexual conduct in the first through fifth degrees as defined in sections 609.342 to 609.3451.
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;
(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; or
(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~~ unless authorized under applicable licensing requirements or Minnesota Rules, Chapter 9544

(c) Any sexual contact or penetration as defined in section 609.341, between a facility staff person or a person providing services in the facility and a resident, patient, or client of that facility.

(d) The act of forcing, compelling, coercing, or enticing a vulnerable adult against the vulnerable adult's will to perform services for the advantage of another.

(e) For purposes of this section, a vulnerable adult is not abused for the sole reason that the vulnerable adult or a person with authority to make health care decisions for the vulnerable adult under sections 144.651, 144A.44, chapter 145B, 145C or 252A, or section 253B.03 or 524.5-313, refuses consent or withdraws consent, consistent with that authority and within the boundary of reasonable medical practice, to any therapeutic conduct, including any care, service, or procedure to diagnose, maintain, or treat the physical or mental condition of the vulnerable adult or, where permitted under law, to provide nutrition and hydration parenterally or through intubation. This paragraph does not enlarge or diminish rights otherwise held under law by:

(1) a vulnerable adult or a person acting on behalf of a vulnerable adult, including an involved family member, to consent to or refuse consent for therapeutic conduct; or

(2) a caregiver to offer or provide or refuse to offer or provide therapeutic conduct.

(f) For purposes of this section, a vulnerable adult is not abused for the sole reason that the vulnerable adult, a person with authority to make health care decisions for the vulnerable adult, or a caregiver in good faith selects and depends upon spiritual means or prayer for treatment or care of disease or remedial care of the vulnerable adult in lieu of medical care, provided that this is consistent with the prior practice or belief of the vulnerable adult or with the expressed intentions of the vulnerable adult.

(g) For purposes of this section, a vulnerable adult is not abused for the sole reason that the vulnerable adult, who is not impaired in judgment or capacity by mental or emotional dysfunction or undue influence, engages in consensual sexual contact with:

(1) a person, including a facility staff person, when a consensual sexual personal relationship existed prior to the caregiving relationship; or

(2) a personal care attendant, regardless of whether the consensual sexual personal relationship existed prior to the caregiving relationship.

Subd. 9.**Financial exploitation.**

"Financial exploitation" means:

(a) In breach of a fiduciary obligation recognized elsewhere in law, including pertinent regulations, contractual obligations, documented consent by a competent person, or the obligations of a responsible party under section 144.6501, a person:

(1) engages in unauthorized expenditure of funds entrusted to the actor by the vulnerable adult which results or is likely to result in detriment to the vulnerable adult; or

(2) fails to use the financial resources of the vulnerable adult to provide food, clothing, shelter, health care, therapeutic conduct or supervision for the vulnerable adult, and the failure results or is likely to result in detriment to the vulnerable adult.

(b) In the absence of legal authority a person:

(c) Nothing in this definition requires a facility or caregiver to provide financial management or supervise financial management for a vulnerable adult except as otherwise required by law.

Subd. 17.**Neglect.**
~~"Neglect" means:~~ Neglect means neglect by a caregiver or self-neglect.
(a) "Caregiver neglect" means" The failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to, food, clothing, shelter, health care, or supervision which is:
(1) reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult; and
(2) which is not the result of an accident or therapeutic conduct.

(b) ~~The absence or likelihood of absence of care or services, including but not limited to, food, clothing, shelter, health care, or supervision necessary to maintain the physical and mental health of the vulnerable adult~~ "Self-neglect" means neglect by a vulnerable adult of the vulnerable adult's own food, clothing, shelter, health care, or other services that are not the responsibility of a caregiver which a reasonable person would deem essential to obtain or maintain the vulnerable adult's health, safety, or comfort. ~~considering the physical or mental capacity or dysfunction of the vulnerable adult~~.

(c) For purposes of this section, a vulnerable adult is not neglected for the sole reason that:
(1) the vulnerable adult or a person with authority to make health care decisions for the vulnerable adult under sections 144.651, 144A.44, chapter 145B, 145C, or 252A, or sections 253B.03 or 524.5-101 to 524.5-502, refuses consent or withdraws consent, consistent with that authority and within the boundary of reasonable medical practice, to any therapeutic conduct, including any care, service, or procedure to diagnose, maintain, or treat the physical or mental condition of the vulnerable adult, or, where permitted under law, to provide nutrition and hydration parenterally or through intubation; this paragraph does not enlarge or diminish rights otherwise held under law by:
(i) a vulnerable adult or a person acting on behalf of a vulnerable adult, including an involved family member, to consent to or refuse consent for therapeutic conduct; or
(ii) a caregiver to offer or provide or refuse to offer or provide therapeutic conduct; or
(2) the vulnerable adult, a person with authority to make health care decisions for the vulnerable adult, or a caregiver in good faith selects and depends upon spiritual means or prayer for treatment or care of disease or remedial care of the vulnerable adult in lieu of medical care, provided that this is consistent with the prior practice or belief of the vulnerable adult or with the expressed intentions of the vulnerable adult;
(3) the vulnerable adult, who is not impaired in judgment or capacity by mental or emotional dysfunction or undue influence, engages in consensual sexual contact with:
(i) a person including a facility staff person when a consensual sexual personal relationship existed prior to the caregiving relationship; or
(ii) a personal care attendant, regardless of whether the consensual sexual personal relationship existed prior to the caregiving relationship; or
(4) an individual makes an error in the provision of therapeutic conduct to a vulnerable adult which does not result in injury or harm which reasonably requires medical or mental health care; or
(5) an individual makes an error in the provision of therapeutic conduct to a vulnerable adult that results in injury or harm, which reasonably requires the care of a physician, and:
(i) the necessary care is provided in a timely fashion as dictated by the condition of the vulnerable adult;

(ii) if after receiving care, the health status of the vulnerable adult can be reasonably expected, as determined by the attending physician, to be restored to the vulnerable adult's preexisting condition;
(iii) the error is not part of a pattern of errors by the individual;
(iv) if in a facility, the error is immediately reported as required under section 626.557, and recorded internally in the facility;
(v) if in a facility, the facility identifies and takes corrective action and implements measures designed to reduce the risk of further occurrence of this error and similar errors; and
(vi) if in a facility, the actions required under items (iv) and (v) are sufficiently documented for review and evaluation by the facility and any applicable licensing, certification, and ombudsman agency.

(d) Nothing in this definition requires a caregiver, if regulated, to provide services in excess of those required by the caregiver's license, certification, registration, or other regulation.

(e) If the findings of an investigation by a lead agency result in a determination of substantiated maltreatment for the sole reason that the actions required of a facility under paragraph (c), clause (5), item (iv), (v), or (vi), were not taken, then the facility is subject to a correction order. An individual will not be found to have neglected or maltreated the vulnerable adult based solely on the facility's not having taken the actions required under paragraph (c), clause (5), item (iv), (v), or (vi). This must not alter the lead agency's determination of mitigating factors under section 626.557, subdivision 9c, paragraph (c).

Policy reviewed and authorized by:

_____

Print Name & Title Signature

Date of last policy review: _____ Date of last policy revision: _____

Legal Authority: Minn. Stat. § 245D.10, subd. 2 and 4