# POLICY AND PROCEDURE ON EMERGENCY USE OF MANUAL RESTRAINT

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 *Coordinated Service and Support Plan (CSSP)* and/or *CSSP Addendum,* 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 *CSSP 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.
   2. Restraint may be used as an intervention procedure to:

# POLICY AND PROCEDURE ON EMERGENCY USE OF MANUAL RESTRAINT

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 *Coordinated Service and Support Plan (CSSP)* and/or *CSSP Addendum,* 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 *CSSP 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.

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 *CSSP 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. ~~section 626.556, subdivision 2~~.
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, 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 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 *Coordinated Service and 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.

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 *CSSP 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. ~~section 626.556, subdivision 2~~.
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 *CSSP 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 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 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 ~~626.556 or~~ 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 may 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.

# POLICY AND PROCEDURE ON REPORTING AND REVIEW OF MALTREATMENT OF MINORS

I. PURPOSE

The purpose of this policy is to establish guidelines for the reporting and internal review of maltreatment of minors (children) in care.

II. POLICY

Staff who are mandated reporters must report externally all of the information they know regarding an incident of known or suspected maltreatment of a child, in order to meet their reporting requirements under law. All staff of MRCI who encounter maltreatment of a minor will take immediate action to ensure the safety of the child. Staff will define maltreatment as sexual abuse, physical abuse, or neglect and will refer to the definitions from MN Statutes, chapter 260E at the end of this policy.

Any person may voluntarily report to the local welfare agency, agency responsible for assessing or investigating the report, police department, the county sheriff, tribal social services agency, or tribal police department if the person knows, has reason to believe, or suspects a child is being ~~neglected or subjected to physical or sexual abuse~~ maltreated. Staff of MRCI cannot shift the responsibility of reporting maltreatment to an internal staff person or position. In addition, if a staff knows or has reason to believe a child is being or has been ~~neglected or physically or sexually abused~~ maltreated within the preceding three years, the staff must immediately (as soon as possible but within 24 hours) make a report to the local welfare agency, agency responsible for assessing or investigating the report, police department, the county sheriff, tribal social services agency, or tribal police department.

Staff will refer to the *Policy and Procedure on Reporting and Review of Maltreatment of Vulnerable Adults* regarding suspected or alleged maltreatment of individuals 18 years of age or older.

III. PROCEDURE

A. Staff of MRCI who encounter maltreatment of a child, age 17 or younger, will take immediate action to ensure the safety of the child or children. If a staff knows or suspects that a child is in immediate danger, they will call “911” or local law enforcement.

B. Staff mandated to report ~~physical or sexual child abuse or neglect~~ maltreatment within a licensed facility will report the information to the agency responsible for licensing the facility. If the mandated reporter is unsure of what agency to contact, they will contact the county agency and follow their direction.

C. Staff who know or suspect that a child has been maltreated but is not in immediate danger will report to:
   1. The local child welfare agency if an alleged perpetrator is a parent, guardian, family child care provider, family foster care provider, or an unlicensed personal care provider.
   2. The Minnesota Department of Human Services, Licensing Division, 651-431-6600, if alleged maltreatment was committed by a staff person at a child care center, residential treatment center (children’s mental health), group home for children, minor parent program, shelter for children, chemical dependency treatment program for adolescents, waivered services program for children, crisis respite program for children, or residential program for children with developmental disabilities.
   3. Minnesota Department of Health, Office of Health Facility Complaints, 651-201-4200 or 800-369-7994, if alleged maltreatment occurred in a home health care setting, hospital, regional treatment center, nursing home, intermediate care facility for the developmentally disabled, or licensed and unlicensed care attendants.

~~D. An individual mandated to report physical or sexual child abuse or neglect maltreatment within a licensed facility will report the information to the agency responsible for licensing the facility. If the mandated reporter is unsure of what agency to contact, they will contact the county agency and follow their direction. The applicable agencies include:~~

~~4. The Department of Human Services is the agency responsible for assessing or investigating allegations of maltreatment in facilities licensed under chapters 245A and 245D, except for child foster care and family child care. DHS Licensing Division's Maltreatment Intake telephone number is 651-431-6600.~~

~~5. The Department of Health is the agency responsible for assessing or investigating allegations of child maltreatment in facilities licensed under sections 144.50 to 144.58 and 144A.46.~~

~~6. The county local welfare agency is the agency responsible for assessing or investigating allegations of maltreatment in child foster care, family child care, legally unlicensed child care, juvenile correctional facilities licensed under section 241.021 located in the local welfare agency's county, and reports involving children served by an unlicensed personal care provider organization under section 256B.0659~~

D. Reports regarding incidents of ~~suspected abuse or neglect~~ maltreatment of children occurring within a family or in the community should be made to the local county social services agency or local law enforcement referencing the phone numbers contained within this policy.

E. When verbally reporting the alleged maltreatment to the external agency, the mandated reporter will include as much information as known to identify the child ~~involved~~, any persons responsible for the ~~abuse or neglect~~ maltreatment (if known), and the nature and extent of the maltreatment, and the name and address of the reporter.

F. If the report of suspected ~~abuse or neglect occurred~~ maltreatment within MRCI, the report should also include any actions taken by MRCI in response to the incident. If a staff attempts to report the suspected maltreatment internally, the person receiving the report will remind the staff of the requirement to report externally.

G. A verbal report of suspected ~~abuse or neglect occurred~~ maltreatment that is made to one of the listed agencies by a mandated reporter must be followed by a written report to the same agency within 72 hours, exclusive of weekends and holidays. ~~unless the appropriate agency has informed the mandated reporter that the oral information does not constitute a report~~.

H. When MRCI has knowledge that an external report of alleged or suspected maltreatment has been made, an internal review will be completed. The 9x9 is the primary individual responsible for ensuring that internal reviews are completed for reports of maltreatment. If there are reasons to believe that the 9x9 is involved in the alleged or suspected maltreatment, the 8x8 is the secondary individual responsible for ensuring that internal reviews are completed.

I. The *Internal Review* will be completed within 30 calendar days. The person completing it 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 children or the services involved
      e. There is a need for corrective action by the license holder to protect the health and safety of

the children in care

5. Complete the *Alleged Maltreatment Review Checklist* and compile together all documents regarding the report of maltreatment.

I. 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.

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

K. Staff will receive training on this policy, MN Statutes, section 245A.66 and chapter 260E and their responsibilities related to protecting children in care from maltreatment and reporting maltreatment. This training must be provided within 72 hours of first providing direct contact services and annually thereafter.

**EXTERNAL AGENCIES**

| COUNTY | DAY | EVENING/WEEKEND |
|---|---|---|
| AITKIN | (218) 927-7200 or (800) 328-3744 | (218) 927-7400 |
| ANOKA | (763) 422-7215 | (651) 291-4680 |
| BECKER | (218) 847-5628 | (218) 847-2661 |
| BELTRAMI | (218) 333-4223 | (218) 751-9111 |
| BENTON | (320) 968-5087 | (320) 968-7201 |
| BIG STONE | (320) 839-2555 | (320) 815-0215 |
| BLUE EARTH | (507) 304-4111 | (507) 625-9034 |
| BROWN | (507) 354-8246 | (507) 233-6720 |
| CARLTON | (218) 879-4511 | (218) 384-3236 |
| CARVER | (952) 361-1600 | (952) 442-7601 |
| CASS | (218) 547-1340 | (218) 547-1424 |
| CHIPPEWA | (320) 269-6401 | (320) 269-2121 |
| CHISAGO | (651) 213-5600 | (651) 257-4100 |
| CLAY | (218) 299-5200 | (218) 299-5151 |
| CLEARWATER | (218) 694-6164 | (218) 694-6226 |
| COOK | (218) 387-3620 | (218) 387-3030 |
| COTTONWOOD | (507) 831-1891 | (507) 831-1375 |
| CROW WING | (218) 824-1140 | (218) 829-4740 |
| DAKOTA | (952) 891-7459 | (952) 891-7171 |
| DODGE | (507) 635-6170 | (507) 635-6200 |
| DOUGLAS | (320) 762-2302 | (320) 762-8151 |
| FARIBAULT | (507) 526-3265 | (507 526-5148 |

| | | |
|---|---|---|
| FILLMORE | (507) 765-2175 | (507) 765-3874 |
| FREEBORN | (507) 377-5400 | (507) 377-5205 |
| GOODHUE | (651) 385-3232 | (651) 385-3155 |
| GRANT | (218) 685-4417 | (800) 797-6190 |
| HENNEPIN | (612) 348-3552 | (612) 348-8526 |
| HOUSTON | (507) 725-5811 | (507) 725-3379 |
| HUBBARD | (218) 732-1451 | (218) 732-3331 |
| ISANTI | (763) 689-1711 | (763) 689-2141 |
| ITASCA | (218) 327-2941 | (218) 326-8565 |
| JACKSON | (507) 847-4000 | (507) 847-4420 |
| KANABEC | (320) 679-6350 | (320) 679-8400 |
| KANDIYOHI | (320) 231-7800 | (320) 235-1260 |
| KITTSON | (218) 843-2689 | (218) 843-3535 |
| KOOCHICHING | (218) 283-7000 | (218) 283-4416 |
| LAC QUI PARLE | (320) 598-7594 | (320) 598-3720 |
| LAKE | (218) 834-8400 | (218) 834-8385 |
| LAKE OF THE WOODS | (218) 634-2642 | (218) 634-1143 |
| LE SUEUR | (507) 357-8288 | (507) 357-8545 |
| LINCOLN | (800) 810-8816 | (507) 694-1664 |
| LYON | (800) 657-3760 | (507) 537-7666 |
| MAHNOMEN | (218) 935-2568 | (218) 935-2255 |
| MARSHALL | (218) 745-5124 | (218) 745-5411 |
| MARTIN | (507) 238-4757 | (507) 238-4481 |
| MC LEOD | (320) 864-3144 | (320) 864-3134 |
| MEEKER | (320) 693-5300 | (320) 693-5400 |
| MILLE LACS | (320) 983-8208 | (320) 983-8250 |
| MORRISON | (320) 632-2951 | (320) 632-9233 |
| MOWER | (507) 437-9700 | (507) 437-9400 |
| MURRAY | (800) 657-3811 | (507) 836-6168 |
| NICOLLET | (507) 386-4528 | (507) 931-1570 |
| NOBLES | (507) 295-5213 | (507) 372-2136 |
| NORMAN | (218) 784-5400 | (218) 784-7114 |
| OLMSTED | (507) 328-6400 | (507) 328-6583 |
| OTTER TAIL | (218) 998-8150 | (218) 998-8555 |
| PENNINGTON | (218) 681-2880 | (218) 681-6161 |

| | | |
|---|---|---|
| PINE | (320) 591-1570 | (320) 629-8380 |
| PIPESTONE | (507) 825-6720 | (507) 825-6792 |
| POLK | (218) 281-8483 | (218) 281-0431 |
| POPE | (320) 634-5750 | (320) 634-5411 |
| RAMSEY | (651) 266-4500 | (651) 291-6795 |
| RED LAKE | (218) 253-4131 | (218) 253-2996 |
| REDWOOD | (507) 637-4050 | (507) 637-4036 |
| RENVILLE | (320) 523-2202 | (320) 523-1161 |
| RICE | (507) 332-6115 | (507) 210-8524 |
| ROCK | (507) 283-5070 | (507) 283-5000 |
| ROSEAU | (218) 463-2411 | (218) 463-1421 |
| SCOTT | (952) 445-7751 | (952) 496-8484 |
| SHERBURNE | (763) 241-2600 | (763) 241-2500 |
| SIBLEY | (507) 237-4000 | (507) 237-4330 |
| ST. LOUIS | N. (218) 749-7128 or S. (218) 726-2012 | N. (218) 749-6010 or S. (218) 727-8770 |
| STEARNS | (320) 656-6225 | (320) 251-4240 |
| STEELE | (507) 444-7500 | (507) 444-3800 |
| STEVENS | (320) 589-7400 | (320) 589-2141 |
| SWIFT | (320) 843-3160 | (320) 843-3133 |
| TODD | (320) 732-4500 | (320) 732-2157 |
| TRAVERSE | (320) 563-8255 | (320) 563-4244 |
| WABASHA | (651) 565-3351 | (651) 565-3361 |
| WADENA | (218) 631-7605 | (218) 631-7600 |
| WASECA | (507) 835-0560 | (507) 835-0500 |
| WASHINGTON | (651) 430-6457 | (651) 291-6795 |
| WATONWAN | (507) 375-3294 | (507) 507-3121 |
| WILKIN | (218) 643-8013 | (218) 643-8544 |
| WINONA | (507) 457-6200 | (507) 457-6368 |
| WRIGHT | (763) 682-7449 | (763) 682-1162 |
| YELLOW MEDICINE | (320) 564-2211 | (320) 564-2130 |

**DEPARTMENT OF HUMAN SERVICES LICENSING DIVISION MALTREATMENT INTAKE: 651-431-6600**

**MINNESOTA STATUTES, CHAPTER 260E.03 DEFINITIONS**

As used in this section, the following terms have the meanings given them unless the specific content indicates otherwise:

Subd. 12. **Maltreatment.** "Maltreatment" means any of the following acts or omissions:
(1) egregious harm under subdivision 5;
(2) neglect under subdivision 15;
(3) physical abuse under subdivision 18;
(4) sexual abuse under subdivision 20;
(5) substantial child endangerment under subdivision 22;
(6) threatened injury under subdivision 23;
(7) mental injury under subdivision 13; and
(8) maltreatment of a child in a facility

Subd. 5. **Egregious harm.** “Egregious harm” means the infliction of bodily harm to a child or neglect of a child which demonstrates a grossly inadequate ability to provide minimally adequate parental care. The egregious harm need not have occurred in the state or in the county where a termination of parental rights action is otherwise properly venued. Egregious harm includes, but is not limited to:
(1) conduct towards a child that constitutes a violation of sections 609.185 to 609.2114, 609.222, subdivision 2, 609.223, or any other similar law of any other state;
(2) the infliction of "substantial bodily harm" to a child, as defined in section 609.02, subdivision 7a;
(3) conduct towards a child that constitutes felony malicious punishment of a child under section 609.377;
(4) conduct towards a child that constitutes felony unreasonable restraint of a child under section 609.255, subdivision 3;
(5) conduct towards a child that constitutes felony neglect or endangerment of a child under section 609.378;
(6) conduct towards a child that constitutes assault under section 609.221, 609.222, or 609.223;
(7) conduct towards a child that constitutes solicitation, inducement, or promotion of, or receiving profit derived from prostitution under section 609.322;
(8) conduct towards a child that constitutes murder or voluntary manslaughter as defined by United States Code, title 18, section 1111(a) or 1112(a);
(9) conduct towards a child that constitutes aiding or abetting, attempting, conspiring, or soliciting to commit a murder or voluntary manslaughter that constitutes a violation of United States Code, title 18, section 1111(a) or 1112(a); or
(10) conduct toward a child that constitutes criminal sexual conduct under sections 609.342 to 609.345

Subd. 15. **Neglect.** (a) "Neglect" means the commission or omission of any of the acts specified under clauses (1) to (8), other than by accidental means:
(1) failure by a person responsible for a child's care to supply a child with necessary food, clothing, shelter, health, medical, or other care required for the child's physical or mental health when reasonably able to do so;
(2) failure to protect a child from conditions or actions that seriously endanger the child's physical or mental health when reasonably able to do so, including a growth delay, which may be referred to as a failure to thrive, that has been diagnosed by a physician and is due to parental neglect;
(3) failure to provide for necessary supervision or child care arrangements appropriate for a child after considering factors as the child's age, mental ability, physical condition, length of absence, or environment, when the child is unable to care for the child's own basic needs or safety, or the basic needs or safety of another child in their care;
(4) failure to ensure that the child is educated as defined in sections 120A.22 and 260C.163, subdivision 11, which does not include a parent's refusal to provide the parent's child with sympathomimetic medications, consistent with section 125A.091, subdivision 5;
(5) prenatal exposure to a controlled substance, as defined in section 253B.02, subdivision 2, used by the mother for a nonmedical purpose, as evidenced by withdrawal symptoms in the child at birth, results of a toxicology test performed on the mother at delivery or the child at birth, medical effects or developmental delays during the child's first year of life that medically indicate prenatal exposure to a controlled substance, or the presence of a fetal alcohol spectrum disorder;
(6) medical neglect, as defined in section 260C.007, subdivision 6, clause (5);
(7) chronic and severe use of alcohol or a controlled substance by a person responsible for the child's care that

adversely affects the child's basic needs and safety; or
(8) emotional harm from a pattern of behavior that contributes to impaired emotional functioning of the child, which may be demonstrated by a substantial and observable effect in the child's behavior, emotional response, or cognition that is not within the normal range for the child's age and stage of development, with due regard to the child's culture.

(b) Nothing in this chapter shall be construed to mean that a child is neglected solely because the child's parent, guardian, or other person responsible for the child's care in good faith selects and depends upon spiritual means or prayer for treatment or care of disease or remedial care of the child in lieu of medical care.

(c) This chapter does not impose upon persons not otherwise legally responsible for providing a child with necessary food, clothing, shelter, education, or medical care a duty to provide that care.

Subd. 18. **Physical abuse.** (a) "Physical abuse" means any physical injury, mental injury under subdivision 13, or threatened injury under subdivision 23, inflicted by a person responsible for the child's care on a child other than by accidental means, or any physical or mental injury that cannot reasonably be explained by the child's history of injuries, or any aversive or deprivation procedures, or regulated interventions, that have not been authorized under section 125A.0942 or 245.825.

(b) Abuse does not include reasonable and moderate physical discipline of a child administered by a parent or legal guardian that does not result in an injury. Abuse does not include the use of reasonable force by a teacher, principal, or school employee as allowed by section 121A.582.

(c) For the purposes of this subdivision, actions that are not reasonable and moderate include, but are not limited to, any of the following:
(1) throwing, kicking, burning, biting, or cutting a child;
(2) striking a child with a closed fist;
(3) shaking a child under age three;
(4) striking or other actions that result in any nonaccidental injury to a child under 18 months of age;
(5) unreasonable interference with a child's breathing;
(6) threatening a child with a weapon, as defined in section 609.02, subdivision 6;
(7) striking a child under age one on the face or head;
(8) striking a child who is at least age one but under age four on the face or head, which results in an injury;
(9) purposely giving a child:
    (i) poison, alcohol, or dangerous, harmful, or controlled substances that were not prescribed for the child by a practitioner in order to control or punish the child; or
    (ii) other substances that substantially affect the child's behavior, motor coordination, or judgment; that result in sickness or internal injury; or that subject the child to medical procedures that would be unnecessary if the child were not exposed to the substances;
(10) unreasonable physical confinement or restraint not permitted under section 609.379, including but not limited to tying, caging, or chaining; or
(11) in a school facility or school zone, an act by a person responsible for the child's care that is a violation under section 121A.58

Subd. 20. **Sexual abuse.** "Sexual abuse" means the subjection of a child by a person responsible for the child's care, by a person who has a significant relationship to the child, or by a person in a current or recent position of authority, to any act that constitutes a violation of section 609.342 (criminal sexual conduct in the first degree), 609.343 (criminal sexual conduct in the second degree), 609.344 (criminal sexual conduct in the third degree), 609.345 (criminal sexual conduct in the fourth degree), 609.3451 (criminal sexual conduct in the fifth degree), or 609.352 (solicitation of children to engage in sexual conduct; communication of sexually explicit materials to children). Sexual abuse also includes any act involving a child that constitutes a violation of prostitution offenses under sections 609.321 to 609.324 or 617.246. Sexual abuse includes all reports of

known or suspected child sex trafficking involving a child who is identified as a victim of sex trafficking. Sexual abuse includes child sex trafficking as defined in section 609.321, subdivisions 7a and 7b. Sexual abuse includes threatened sexual abuse, which includes the status of a parent or household member who has committed a violation that requires registration as an offender under section 243.166, subdivision 1b, paragraph (a) or (b), or required registration under section 243.166, subdivision 1b, paragraph (a) or (b).

Subd. 22. **Substantial child endangerment.** "Substantial child endangerment" means that a person responsible for a child's care, by act or omission, commits or attempts to commit an act against a child under their care that constitutes any of the following:
(1) egregious harm under subdivision 5;
(2) abandonment under section 260C.301, subdivision 2;
(3) neglect under subdivision 15, paragraph (a), clause (2), that substantially endangers the child's physical or mental health, including a growth delay, which may be referred to as failure to thrive, that has been diagnosed by a physician and is due to parental neglect;
(4) murder in the first, second, or third degree under section 609.185, 609.19, or 609.195;
(5) manslaughter in the first or second degree under section 609.20 or 609.205;
(6) assault in the first, second, or third degree under section 609.221, 609.222, or 609.223;
(7) solicitation, inducement, and promotion of prostitution under section 609.322;
(8) criminal sexual conduct under sections 609.342 to 609.3451;
(9) solicitation of children to engage in sexual conduct under section 609.352;
(10) malicious punishment or neglect or endangerment of a child under section 609.377 or 609.378;
(11) use of a minor in sexual performance under section 617.246; or
(12) parental behavior, status, or condition that mandates that the county attorney file a termination of parental rights petition under section 260C.503, subdivision 2.

Subd. 23. **Threatened injury.** (a) "Threatened injury" means a statement, overt act, condition, or status that represents a substantial risk of physical or sexual abuse or mental injury.

(b) Threatened injury includes, but is not limited to, exposing a child to a person responsible for the child's care, as defined in subdivision 17, who has:
(1) subjected a child to, or failed to protect a child from, an overt act or condition that constitutes egregious harm under subdivision 5 or a similar law of another jurisdiction;
(2) been found to be palpably unfit under section 260C.301, subdivision 1, paragraph (b), clause (4), or a similar law of another jurisdiction;
(3) committed an act that resulted in an involuntary termination of parental rights under section 260C.301, or a similar law of another jurisdiction; or
(4) committed an act that resulted in the involuntary transfer of permanent legal and physical custody of a child to a relative under Minnesota Statutes 2010, section 260C.201, subdivision 11, paragraph (d), clause (1), section 260C.515, subdivision 4, or a similar law of another jurisdiction.

(c) A child is the subject of a report of threatened injury when the local welfare agency receives birth match data under section 260E.14, subdivision 4, from the Department of Human Services.

Subd. 13. **Mental injury.** "Mental injury" means an injury to the psychological capacity or emotional stability of a child as evidenced by an observable or substantial impairment in the child's ability to function within a normal range of performance and behavior with due regard to the child’s culture.

# 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 and must not terminate services unless:
   1. The termination is necessary for the person's welfare and the facility cannot meet the person's needs; ~~cannot be met in the facility~~;
   2. The safety of the person or others in the program 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 would otherwise be endangered;
   4. The program has not been paid for services;
   5. The program 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.