MDH

test1 Home Incident Reporting User Management Logout

Incident Report

Session Timeout in 14:37 minutes.
Please save your incident report before timer reaches 00:00 to avoid loss of data entered into the report.

Required fields for submission to Minnesota Department of Health are marked with an asterisk (*).

Submit to MDH | Save as Draft

Incident tracking ID
0

Incident status
draft

Date and time submitted to MDH

Incident created by
test1

Facility name
ESSENTIA HEALTH NORTHERN PINES

Facility HFID
00604

Facility phone
(218) 229-4222

Facility address
5211 HIGHWAY 110, AURORA, MN

Resident 1

Check if resident 1 is a current resident
☐

First name*

Last name*

Date of birth (MM/DD/YYYY)*

Gender*
Select One

Facility type where the resident is receiving services*
Select One

Ethnicity/Race

Select One

Check if the resident identifies as Hispanic or Latino

☐

Pertinent diagnosis *

1000 characters remaining.

Current location of alleged victim

Check if the resident has been transferred to hospital (Hospital name is then required)

☐

Hospital name

255 characters remaining.

Check if the resident has been discharged (discharge location is then required)

☐

Discharge location name and address

255 characters remaining.

Discharge city

Discharge state

Select One

Discharge zip

Resident 2

Check if resident 2 is a current resident

☐

First name

Last name

Date of birth (MM/DD/YYYY)

Gender

Select One

Ethnicity/Race

Select One

Check if the resident identifies as Hispanic or Latino

☐

Facility type where the resident is receiving services

Select One

Pertinent diagnosis

1000 characters remaining.

Check if the resident has been transferred to hospital (Hospital name is then required)

☐

Hospital name

255 characters remaining.

Check if the resident has been discharged (discharge location is then required)

☐

Discharge location name and address

255 characters remaining.

Discharge city

Discharge state

Select One

Discharge zip

Initial Reporter

Check if initial reporter and submitter are the same person

☐

Date/Time of when staff became aware of incident *

Relationship or staff position to resident 1 *

Select One

If other please specify

First name

Last name

Address

City

State

Select One

Zip

Date/Time administrator was notified of the incident *

Administrator was notified by whom *

100 characters remaining.

Allegations (check all applicable allegations, selection of at least one allegation is required)

Please review the user guide for the detailed explanations of each allegation type

Sexual Abuse

Criminal sexual conduct 1st-5th degree

Sexual contact or penetration between resident and service provider or facility staff

Sexual contact with lack of capacity to consent

Solicitation, inducement or promotion of the resident in prostitution

Unwanted sexual contact

Physical Abuse

Biting

- [ ] **Burn**
- [ ] **Conduct intended to produce pain/injury or rough handling.**
- [ ] **Corporal/physical punishment**
- [ ] **Criminal assault 1st-5th degree**
- [ ] **Forced separation of the resident to perform services for another**
- [ ] **Hitting or punching**
- [ ] **Kicking**
- [ ] **Slapping**
- [ ] **Unexplained Injury**
- [ ] **Unreasonable confinement, involuntary seclusion**
- [ ] **Use of chemical restraint**
- [ ] **Use of drugs to injure or facilitate crime**
- [ ] **Use of manual or physical restraint**
- [ ] **Forcing, compelling, enticing resident to perform services for another**

Neglect

- [ ] **Burn**
- [ ] **Elopement**
- [ ] **Resident to Resident Altercation**
- [ ] **Death**
- [ ] **Unsafe Smoking**
- [ ] **Dehydration**
- [ ] **Pressure Ulcers**
- [ ] **Pain Management**
- [ ] **Falls**

Clothing

☐

Food

☐

Health Care

☐

Medication

☐

Services

☐

Shelter

☐

Supervision

☐

Unexplained Injury

☐

Weight Loss

☐

Lack of supervision leading to physical or sexual harm

☐

Emotional or Mental Abuse

Forced separation of the resident from another person against the wishes of the resident, or legal representative's wishes

☐

Gestured communication

☐

Oral communication

☐

Punishment

☐

Written communication

☐

Self Neglect

If you are reporting an AMA because you are concerned about an individual’s safety once they leave the facility against medical advice and the facility staff have followed required procedures for discharge then report directly to MAARC.

Clothing

☐

Food

☐

Health Care

☐

Medication

☐

Shelter

☐

Supervision

☐

Unexplained Injury

☐

AMA

☐

Services essential to welfare or safety of the person

☐

Financial Exploit (non-fiduciary)

Forcing, compelling, enticing resident to perform services for another

☐

Funds failed to be used for benefit of the resident

☐

Spends or uses the money or possessions of the resident without authority

☐

Theft of medication

☐

Theft of money or possessions

☐

Theft of property

☐

Withholds the resident's money or possessions from the resident

☐

Acquired possession/ownership/control of resident's money/possessions using undue influence/harassment/duress/fraud

☐

Financial Exploit (fiduciary)

Forcing, compelling, enticing resident to perform services for another

☐

Funds failed to be used for benefit of the resident

☐

Spends or uses the money or possessions of the resident without authority

☐

Theft of medication

☐

Theft of money or possessions

☐

Theft of property

☐

Withholds the resident's money or possessions from the resident

☐

Acquired possession/ownership/control of resident's money/possessions using undue influence/harassment/duress/fraud

☐

Alleged Perpetrator's Financial Relationship to resident

Select One

Incident Details

Check if the incident resulted in serious bodily injury to the resident

☐

Check if the incident resulted in death of resident

☐

Description of physical injury or pain *

512 characters remaining.

Description of any mental anguish outcome, including but not limited to crying, expressions or displays of fear, cowering, anger, withdrawal, difficulty sleeping, etc. *

500 characters remaining.

Date and time of incident (MM/DD/YYYY HH:MM:SS) *

Who made the allegation (indicate if anonymous), and their relationship to the alleged victim *

Location of incident *

County that the incident occurred in

Select One

Description of incident *

5000 characters remaining.

Provide all steps taken immediately to ensure resident(s) are protected (See Examples Below): *

5000 characters remaining.

Examples:

- ***Immediate assessment of the alleged victim and provision of medical treatment as necessary;***
- ***Evaluation of whether the alleged victim feels safe and if he/she does not feel safe, taking immediate steps to protect the resident, such as a room relocation and/or increased supervisio***

- *Immediate notification to the alleged perpetrator's (if a resident) and/or the alleged victim's physician and the resident representative when there is injury, a significant change in conditi*
- *If the alleged perpetrator is facility/agency staff, removal of the alleged perpetrator's access to the alleged victim and other residents and assurance that ongoing safety and protection i*
- *If the alleged perpetrator is a resident or visitor, removal of the alleged perpetrator's access to the alleged victim and, as appropriate, other residents and assurance that ongoing safety*
- *Other measures the facility is taking to prevent further potential abuse, neglect, exploitation, and misappropriation of resident property.*

Alleged perpetrator 1 information

Relationship or staff position to resident 1 *

Select One

If other please specify

If staff please specify position

First name

Middle name

Last name

Estimated age

0

Gender

Select One

Contact information (if known)

Address

City

State

Select One

Zip

Check if there is evidence of previous incident(s) by the alleged perpetrator

☐

Nature of previous incident(s)

Alleged perpetrator 2 information

Relationship or staff position to resident 1

There is no alleged perpetrator

If other please specify

If staff please specify position

First name

Middle name

Last name

Estimated age

0

Gender

Select One

Contact information (if known)

Address

City

State

Select One

Zip

Check if there is evidence of previous incident(s) by the alleged perpetrator

☐

Nature of previous incident(s)

Alleged perpetrator 3 information

Relationship or staff position to resident 1

There is no alleged perpetrator

If other please specify

If staff please specify position

First name

Middle name

Last name

Estimated age

0

Gender

Select One

Contact information (if known)

Address

City

State

Select One

Zip

Check if there is evidence of previous incident(s) by the alleged perpetrator

Nature of previous incident(s)

Responsible Persons Information

Relationship or staff position to resident 1

Select One

First name

Last name

Address

City

State

Select One

Zip

Phone

Alternate phone

County Case Manager Information

First name

Last name

Phone

Alternate phone

Additional Contact Information

First name

Last name

Relationship or staff position to resident 1

Phone

Alternate phone

Referral Information

Check if there is suspected criminal activity

☐

Check if the police were contacted

☐

Type of crime

Date and time of police notification

Police report number

Name of police department

Police department phone

Name and position of staff who reported to police if different than submitter

100 characters remaining.

Were other agencies notified (e.g. Adult Protective Services, NA registry, Board of Nursing)? If yes, which agency, who was notified at that agency, and what was the date and time of notification? *

250 characters remaining.

Check if the medical examiner was notified

☐

Check if the ombudsman for long term care was notified

☐

Check if an incident of sexual assault is alleged within the past three weeks and resident has not received a sexual assault examination

☐

Check if the resident is likely to be physically abused or sexually assaulted within the next 72 hours

☐

Check if the resident is likely to be a victim of abuse, neglect or exploitation which will likely result in serious injury, harm or loss of health requiring medical care by a physician within the next 72 hours

☐

Witness Information

Witness 1

First name

Last name

Phone

Alternate phone

Relationship or staff position to resident 1

Witness 2

First name

Last name

Phone

Alternate phone

Relationship or staff position to resident 1

Witness 3

First name

Last name

Phone

Alternate phone

Relationship or staff position to resident 1

Witness 4

First name

Last name

Phone

Alternate phone

Relationship or staff position to resident 1

Witness 5

First name

Last name

Phone

Alternate phone

Relationship or staff position to resident 1

Submit to MDH | Save as Draft

For assistance contact MDH by email at: Health.OHFCNHRS@state.mn.us

Version: 1.6.0