



facilityadmin Home Incident Reporting User Management Logout

## Incident 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** facilityadmin

**Facility name** HIGHLAND CHATEAU HCC

**Facility HFID** 00494

### Resident 1

**Check if resident 1 is a current resident**

**First name\***

**Last name\***

**Date of birth (MM/DD/YYYY)\***

**Gender\***

**Facility type where the resident is receiving services\***

**Ethnicity/Race**

Select One 

**Check if the resident identifies as Hispanic or Latino**

**Pertinent diagnosis\***

1000 characters remaining.

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

**Hospital name**

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

**Discharge location address**

**Discharge city**

**Discharge state**

Select One 

**Discharge zip**

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## Resident 2

**Check if resident 2 is a current resident**

**First name**

**Last name**

**Date of birth  
(MM/DD/YYYY)**

**Gender**

 ▾

**Ethnicity/Race**

 ▾

**Check if the resident  
identifies as Hispanic  
or Latino**

**Facility type where the  
resident is receiving  
services**

 ▾

**Pertinent diagnosis**

  
1000 characters remaining.

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

**Hospital name**

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

**Discharge location  
address**

**Discharge city**

**Discharge state**

 ▾

**Discharge zip**

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## Initial Reporter

**Check if initial  
reporter and submitter  
are the same person**

<b>Relationship to resident 1*</b>	<input type="text" value="Select One"/>
<b>If other please specify</b>	<input type="text"/>
<b>First name</b>	<input type="text"/>
<b>Last name</b>	<input type="text"/>
<b>Address</b>	<input type="text"/>
<b>City</b>	<input type="text"/>
<b>State</b>	<input type="text" value="Select One"/>
<b>Zip</b>	<input type="text"/>

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**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 VA and service provider or facility staff**
- Sexual contact with lack of capacity to consent**
- Solicitation, inducement or promotion of the VA in prostitution**
- Unwanted sexual contact**

**Physical Abuse**

- |   |                          |
|---|--------------------------|
| <b>Biting</b>   | <input type="checkbox"/> |
| <b>Burn</b>   | <input type="checkbox"/> |
| <b>Conduct intended to produce pain, injury</b>                               | <input type="checkbox"/> |
| <b>Corporal/physical punishment</b>   | <input type="checkbox"/> |
| <b>Criminal assault 1st-5th degree</b>  | <input type="checkbox"/> |
| <b>Forced separation of the VA to perform services for another</b>            | <input type="checkbox"/> |
| <b>Hitting or punching</b>  | <input type="checkbox"/> |
| <b>Kicking</b>  | <input type="checkbox"/> |
| <b>Slapping</b>   | <input type="checkbox"/> |
| <b>Unexplained Injury</b>   | <input type="checkbox"/> |
| <b>Unreasonable confinement, involuntary seclusion</b>                        | <input type="checkbox"/> |
| <b>Use of chemical restraint</b>  | <input type="checkbox"/> |
| <b>Use of drugs to injure or facilitate crime</b>                             | <input type="checkbox"/> |
| <b>Use of manual or physical restraint</b>                                    | <input type="checkbox"/> |
| <b>Forcing, compelling, enticing resident to perform services for another</b> | <input type="checkbox"/> |

### Neglect

- |   |                          |                        |                          |
|---|--------------------------|------------------------|--------------------------|
| <b>Burn</b>                             | <input type="checkbox"/> | <b>Elopement</b>       | <input type="checkbox"/> |
| <b>Resident to Resident Altercation</b> | <input type="checkbox"/> | <b>Death</b>           | <input type="checkbox"/> |
| <b>Unsafe Smoking</b>                   | <input type="checkbox"/> | <b>Dehydration</b>     | <input type="checkbox"/> |
| <b>Pressure Ulcers</b>                  | <input type="checkbox"/> | <b>Pain Management</b> | <input type="checkbox"/> |
| <b>Falls</b>                            | <input type="checkbox"/> | <b>Clothing</b>        | <input type="checkbox"/> |

<b>Food</b>	<input type="checkbox"/>	<b>Health Care</b>	<input type="checkbox"/>
<b>Medication</b>	<input type="checkbox"/>	<b>Services</b>	<input type="checkbox"/>
<b>Shelter</b>	<input type="checkbox"/>	<b>Supervision</b>	<input type="checkbox"/>
<b>Unexplained Injury</b>	<input type="checkbox"/>	<b>Weight Loss</b>	<input type="checkbox"/>
<b>Lack of supervision leading to physical or sexual harm</b>	<input type="checkbox"/>		

**Emotional or Mental Abuse**

<b>Forced separation of the VA from another person against the wishes of the VA, or legal representative's wishes</b>	<input type="checkbox"/>
<b>Gestured communication</b>	<input type="checkbox"/>
<b>Oral communication</b>	<input type="checkbox"/>
<b>Punishment</b>	<input type="checkbox"/>
<b>Written communication</b>	<input type="checkbox"/>

**Self Neglect**

<b>Clothing</b>	<input type="checkbox"/>	<b>Food</b>	<input type="checkbox"/>
<b>Health Care</b>	<input type="checkbox"/>	<b>Medication</b>	<input type="checkbox"/>
<b>Shelter</b>	<input type="checkbox"/>	<b>Supervision</b>	<input type="checkbox"/>
<b>Unexplained Injury</b>	<input type="checkbox"/>	<b>AMA</b>	<input type="checkbox"/>
<b>Services essential to welfare or safety of the person</b>	<input type="checkbox"/>		

## Financial Exploit (non-fiduciary)

- Forcing, compelling, enticing VA to perform services for another**
- Funds failed to be used for benefit of the VA**
- Spends or uses the money or possessions of the VA without authority**
- Theft of medication**
- Theft of money or possessions**
- Theft of property**
- Withholds the VA's money or possessions from the VA**
- Acquired possession/ownership/control of VA's money/possessions using undue influence/harassment/duress/fraud**

## Financial Exploit (fiduciary)

- Forcing, compelling, enticing VA to perform services for another**
- Funds failed to be used for benefit of the VA**
- Spends or uses the money or possessions of the VA without authority**
- Theft of medication**
- Theft of money or possessions**
- Theft of property**
- Withholds the VA's money or possessions from the VA**

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

**Alleged  
Perpetrator's  
Financial  
Relationship  
to VA**

Select One ▼

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## Incident Details

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

**Check if the incident  
resulted in death of  
resident**

**Description of injury**

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

**Location of incident\***

**County that the  
incident occurred in**  ▼

**Description of  
incident\***

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## Alleged perpetrator 1 information

Select One ▼

**Relationship to resident 1\*****If other please specify****First name****Middle name****Last name****Estimated age****Gender****Address****City****State****Zip****Check if there is evidence of previous incident(s) by the alleged perpetrator****Nature of previous incident(s)**

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**Alleged perpetrator 2 information****Relationship to resident 1****If other please specify****First name****Middle name****Last name****Estimated age**

<b>Gender</b>	Select One ▾
<b>Address</b>	<input type="text"/>
<b>City</b>	<input type="text"/>
<b>State</b>	Select One ▾
<b>Zip</b>	<input type="text"/>
<b>Check if there is evidence of previous incident(s) by the alleged perpetrator</b>	<input type="checkbox"/>
<b>Nature of previous incident(s)</b>	<input type="text"/>

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### Alleged perpetrator 3 information

<b>Relationship to resident 1</b>	There is no alleged perpetrator ▾
<b>If other please specify</b>	<input type="text"/>
<b>First name</b>	<input type="text"/>
<b>Middle name</b>	<input type="text"/>
<b>Last name</b>	<input type="text"/>
<b>Estimated age</b>	<input type="text" value="0"/>
<b>Gender</b>	Select One ▾
<b>Address</b>	<input type="text"/>
<b>City</b>	<input type="text"/>
<b>State</b>	Select One ▾
<b>Zip</b>	<input type="text"/>
<b>Check if there is evidence of previous</b>	<input type="checkbox"/>

**incident(s) by the  
alleged perpetrator**

**Nature of previous  
incident(s)**

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### Responsible Persons Information

**Relationship to  
resident 1**

 ▼

**First name**

**Last name**

**Address**

**City**

**State**

 ▼

**Zip**

**Phone**

**Alternate phone**

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### County Case Manager Information

**First name**

**Last name**

**Phone**

**Alternate phone**

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### Additional Contact Information

**First name**

**Last name**

**Relationship to resident 1**

**Phone**

**Alternate phone**

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## Referral Information

**Check if there is suspected criminal activity**

**Check if the police were contacted**

**Type of crime**

**Date of police notification**

**Police report number**

**Name of police department**

**Police department phone**

**Check if the medical examiner was notified**

**Check if the ombudsman for long term care was notified**

**Check if the resident was recently sexually assaulted and has not received a sexual assault examination**

**Check if the resident is in immediate risk of**

**physical assault or sexual assault or abuse**

**Check if the resident is believed to be at risk of serious injury**

**Check if action has been taken to protect the resident**

**What action was taken to protect the resident**

1000 characters remaining.

### Witness Information

<p><b>Witness 1</b></p> <p><b>First name</b> <input type="text"/></p> <p><b>Last name</b> <input type="text"/></p> <p><b>Phone</b> <input type="text"/></p> <p><b>Alternate phone</b> <input type="text"/></p> <p><b>Relationship to resident 1</b> <input type="text"/></p>	<p><b>Witness 2</b></p> <p><b>First name</b> <input type="text"/></p> <p><b>Last name</b> <input type="text"/></p> <p><b>Phone</b> <input type="text"/></p> <p><b>Alternate phone</b> <input type="text"/></p> <p><b>Relationship to resident 1</b> <input type="text"/></p>
<p><b>Witness 3</b></p> <p><b>First name</b> <input type="text"/></p> <p><input type="text"/></p>	<p><b>Witness 4</b></p> <p><b>First name</b> <input type="text"/></p> <p><input type="text"/></p>

<p><b>Last name</b></p> <p><b>Phone</b> <input type="text"/></p> <p><b>Alternate phone</b> <input type="text"/></p> <p><b>Relationship to resident 1</b> <input type="text"/></p>	<p><b>Last name</b></p> <p><b>Phone</b> <input type="text"/></p> <p><b>Alternate phone</b> <input type="text"/></p> <p><b>Relationship to resident 1</b> <input type="text"/></p>
<p><b>Witness 5</b></p> <p><b>First name</b> <input type="text"/></p> <p><b>Last name</b> <input type="text"/></p> <p><b>Phone</b> <input type="text"/></p> <p><b>Alternate phone</b> <input type="text"/></p> <p><b>Relationship to resident 1</b> <input type="text"/></p>	
<p><input type="button" value="Submit to MDH"/> <input type="button" value="Save as Draft"/></p>	

For assistance contact MDH by email at: [Health.OHFCNHR@state.mn.us](mailto:Health.OHFCNHR@state.mn.us)

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