



Culture of Safety, Systemic Critical Incident Review: Annual public report

Disability Services Division

October 2024

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ការយកចិត្តទុកដាក់។ ប្រសិនបើអ្នកត្រូវការជំនួយឥតគិតថ្លៃ ដើម្បី បកស្រាយឯកសារនេះ សូមហៅទូរសព្ទទៅលេខក្នុងប្រអប់ខាងលើ។ Cambodian

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wánj. héćinhanj niyé wačínjyAnj wayúiyeska ki de wówapi sutá, ečýA kin wóiyawa ed ophiye wanj. Dakota

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સાવધાન. જો તમને આ દસ્તાવેજને સમજવા માટે નિઃશુલ્ક મદદની જરૂર હોય, તો ઉપરના બોક્સ પૈકીના નંબર પર કોલ કરો. Gujarati

ध्यान दें। यदि आपको इस दस्तावेज़ की व्याख्या में निशुल्क सहायता की आवश्यकता है, तो ऊपर बॉक्स में दिए गए नंबर पर कॉल करें। Hindi

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Lus Ceeb Toom. Yog tias koj xav tau kev pab txhais lus dawb ntawm cov ntaub ntawv no, ces hu rau tus nab npawb xov tooj nyob hauv lub npov plaub fab saum toj no. Hmong

ဟ်သုဉ်ဟ်သး. နမ့ၢ်လိဉ်ဘဉ် တၢ်မၤစၢၤကလီၤလၢ ကကျိးထံလံာ်တီၢ်မိတဖဉ်အယိ, ကိးနီဉ်ဂံၢ်လၢ အအိဉ်ဖဲတၢ်လွံၢ်န့ၢ် လၢတၢ်ဖီခိဉ်အပူၤတက့ၢ်. Karen

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تکایه سهرنج بده. ئەگەر بۆ وەرگیرانی ئەم بەلگەنامەیە پێویستت بە یارمەتی بێبەرامبەرە، ئەوا
پەیوەندی بەو ژمارەیەو بەکە کە لە بۆکسەکەی سەر موەدایە. Kurdish Sorani

Baldarî. Ger ji bo wergerandina vê belgeyê hewcedariya we bi alîkariya belaş hebe, ji kerema xwe bi hejmara li qutîya jorîn re telefon bikin. Kurdish Kurmanji

Hoǰpín. Tóhán wanǵí thí wíyukčanpi kin yuhá níyunspe hécha čhéya, lé tkíčhun kin k'é nánpa opáwinyan. Lakota

ເອົາໃຈໃສ່. ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອພຣີໃນການຕີຄວາມເອກະສານນີ້,
ໃຫ້ໃບຫາເບີທີ່ຢູ່ໃນບ່ອງຂ້າງເທິງ. Lao

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Mandarin (Simplified Chinese)

P̄alɛ ɾɔ piny: Mi gööri luäk lɔrä kɛ luɔɕ kä mɛmɛ, yɔtni nämbär ɛmɔ tɛë
nhial guäth ɛmɛ. Nuer

Mah Biz'sin'dan.

Keesh'pin nan'deh'dam'mun chi'wee'chi'goo'yan chi'nis'too'ta'man
oo'weh ooshii'be'kan.

Ishi'kidoon ah'kin'das'soon ka'ooshi'bee'kadehk ish'peh'mik ka'shi
ka'ka'kak. Ojibwe

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Zingatia. Iwapo unahitaji msaada usio na malipo wa kutafsiri hati hii, piga simu kwa namba iliyo kwenye kisanduku hapo juu. Swahili

ልቢ በሉ፡ ነዚ ሰነድ ንምትርጓም ነፃ ሓገዝ እንተ ደልዮም፣ በቲ ኣብ ላዕሊ ኣብ ውሽጢ ሰደቓ ተቐጥሊጡ ዘሎ ቁጽሪ ይደውሉ። Tigrinya

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Àkíyèsí. Tí o bá nílò ìrànlowó pèlú tí tú mò àkòólẹ̀ yìí, pe nọmbà tó wà nínú àpótí tí wà ló kẹ. Yoruba

LB (7-24)



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(ADA1[9-15])

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I. Introduction

Purpose of report

The Minnesota Department of Human Services (DHS), Disability Services Division (DSD) is required to provide an annual public report on the [Culture of Safety systemic critical incident review model](#) that documents and informs the commissioner of systemic changes that might decrease the amount and severity of critical incidents in the future, improve outcomes and enhance services provided in home and community-based settings.

This annual report provides updates on DSD's Culture of Safety systemic critical incident review model during the reporting period of Oct. 1, 2023, to Sept. 30, 2024. It contains information including the number and types of incidents reviewed, an aggregate summary of the systemic themes within the incidents, a synopsis of conclusions examined and recommendations for systemic changes. We developed recommendations in partnership with three [regional quality councils](#) that represent metropolitan and rural counties in Minnesota.

Culture of Safety background

The Culture of Safety initiative, which follows the [Collaborative Safety framework](#), utilizes a systematic review model to proactively assess the response to incidents. Rather than determining the culpability of any actors involved in the incident, the model focuses on learning and engaging direct care workers, identifying systemic barriers and challenges and their influences at different levels of the disability service system, and making recommendations that would improve outcomes within disability services.

In June 2019, DSD began to review critical incidents that occurred in 245D-licensed facilities using the Culture of Safety systemic critical incident review model.

The incidents were obtained via behavior intervention reporting forms, 245D residential service terminations and/or suspensions, and/or reports submitted to DHS as the lead investigative agency. These were reported for suspected maltreatment and closed following the initial disposition in accordance with [Minnesota Statutes, section 256.01, subdivision 12b, paragraph \(b\)](#). A selection committee made up of DHS and lead agency staff chose the critical incidents. DSD assigned the selected incidents to a trained safety analyst for review.

DSD trains safety analysts, consisting of lead agency and DHS staff, to conduct critical incident reviews using the Culture of Safety model. The assigned safety analyst engages 245D-licensed providers and facility staff to learn more about their experiences within the critical incident. Following the critical incident review, the safety analyst facilitates a discussion with a "mapping team" consisting of staff from lead agencies, providers and DHS. The mapping activity identifies systemic barriers and challenges at different levels of the disability service system, refrains from blaming others and incorporates multiple viewpoints from across service systems.

II. Incident review overview

Since June 2019, DSD trained 31 safety analysts to conduct critical incident reviews using the Culture of Safety critical incident review model. Between June 1, 2019, and June 30, 2024, DSD selected 76 critical incidents by incident type which were reviewed by assigned safety analysts. During this annual reporting period, we completed six new critical incident reviews.

Below are the incident types reviewed and their corresponding definitions.

Critical incident types and definitions

Medication error

Person received the wrong medication/dosage; person gained access to medications; medication administration policy not followed.

Supervision not maintained

Person left home and staff did not know; staff unable to follow person who left the home.

Service termination and/or suspension

Person received a 245D service termination and/or suspension.

Staff sleeping

Staff sleeping during shift.

Wheelchair safety

Foot pedals not on; seatbelt not secured.

Other

Not following COVID protocol.

Below is a table displaying the 76 incidents DHS reviewed, by incident type and lead agency regions. The four regions include:

- 1. Blue Earth, Olmsted
- 2. Clay, Otter Tail, Polk
- 3. Dakota, Hennepin
- 4. St. Louis

Table 1: Number of critical incidents reviewed by lead agency and incident type

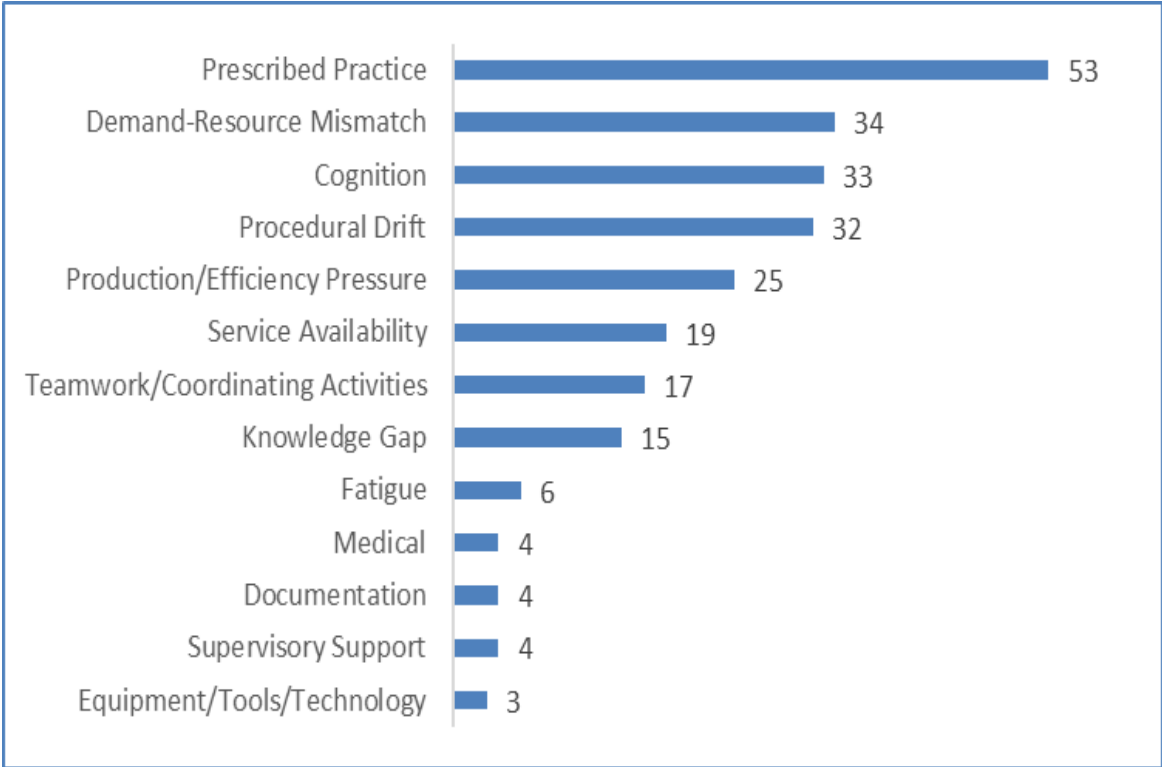
Incident type	Region 1	Region 2	Region 3	Region 4	Total
Medication error	<10	<10	12	<10	29
Elopement	<10	<10	<10	<10	21
Service termination and/or suspension	<10	<10	<10	<10	17
Staff sleeping	<10	0	<10	<10	<10
Wheelchair safety	<10	0	<10	<10	<10
Other	0	0	0	<10	<10

Note: when the number of incident reviews was 10 or fewer in a particular region, "<10 (i.e. fewer than 10)" is used to reduce the chance of identifying individuals.

Each critical incident review collects information pertaining to the 245D-licensed provider and the facility staff's decision-making during the critical incident to build a greater understanding of how the service system (e.g. policies, rules, statutes) influenced the incident. At the end of each incident review, reviewers score the data using an analysis tool to assess systemic themes. The systemic themes allow DHS to group the data to narrow the focus and better understand identified systemic barriers and challenges within incident types.

Below are the number of systemic themes scored for the 76 critical incidents reviewed and the definitions of the systemic themes. Note: Each incident review might be scored with more than one systemic theme.

Figure 1: Number of systemic themes scored across 76 critical incident reviews



Below are the definitions of the systemic themes in the chart above.

Prescribed practice

When policy or work expectations are absent, conflicting, not clear or do not support the work.

Demand-resource mismatch

The agency does not have resources available to help staff do their work (e.g., no or limited training for onboarding staff, staff shortages) or the resources available are not enough or do not support the work.

Cognition

Not fully understanding a situation because providers focused on beliefs and past experiences or focused on only one way to do things when there were other options.

Procedural drift

Staff members take shortcuts or use workarounds because of challenges (e.g. staff shortages, what worked before doesn't now), co-workers' suggestions or the new way worked.

Production/efficiency pressure

Pressure is placed on staff to meet goals, do more work and/or work more quickly, which negatively affects the work.

Service availability

External services or supports are not available or they are difficult to find/access.

Teamwork/coordinating activities

When two or more partners (internal and/or external) are not able to work together to complete the goals (e.g., direct support professionals and clinical staff, day staff and overnight staff)

Knowledge gap

Staff do not have experience and/or knowledge and/or have difficulty using their knowledge in their work.

Fatigue

Staff being tired affects their work.

Medical

Difficulties receiving or understanding medical records or adding medical information into plans of care.

Documentation

Electronic or paper documentation is missing, not complete or inconsistent.

Supervisory support

Supervisors have difficulty providing support, supervision, sharing knowledge or being available.

Equipment/tools/technology

The equipment, tools and/or technology is not available or does not support work.

III. Incident review analysis and considerations

Initially DHS partnered with three regional quality council workgroups to help analyze the critical incident review data and consider recommendations for change within disability services. The regional quality council workgroups collaborate with regional partners to help drive systems and social change to promote inclusion of disabled people in the state, as well as monitor and improve the quality of services, person-centered outcomes and overall quality of life for people with disabilities. At the time of this report, DHS partnered with four regional quality council workgroups that represented 19 Minnesota counties; however, the fourth workgroup did not complete a full review of incident data in 2023 and will be included in the next annual report.

During this annual report, three regional quality council workgroups reviewed data from 25 critical incident reviews related to service terminations and/or suspensions and medication errors and proposed considerations for systemic change to better support lead agencies, providers and/or people who receive services.

One workgroup reviewed data from nine service termination and/or suspension incident reviews. These incidents included service terminations that providers issued to people who receive services who engaged in behaviors that affected the provider's ability to maintain the health and safety of the person, others in the program and/or staff.

Systemic barriers or challenges that surfaced from the 2023 data review of critical incidents related to service terminations and/or suspensions included:

- Providers might not be able to support a person who receives services when a person with complex needs engages in behaviors that might be detrimental to the health and safety of themselves or others, such as: physical aggression, property destruction, substance use or noncompliance with medical treatment.
- A service termination and/or suspension might be necessary for the person's welfare as the provider cannot meet the person's needs or effectively maintain safety of the person or others.

Two workgroups reviewed data from 16 medication error incident reviews. These reviews included medication storage/security policies not being followed such as: medication storage doors were unlocked, documentation steps were not completed or the person received the wrong medication/dosage.

Systemic barriers or challenges that surfaced from the 2023 data review of critical incidents related to medication errors included:

- Staff perceive checking the Medication Administration Record (MAR) as duplicative when medications were packaged in bubble packs by the pharmacy and checked again when they arrived at the facility.
- When staff are busy with numerous tasks (e.g. supporting multiple people with activities of daily living and the need to administer medications at the right time), they might feel pressured to administer medications quickly.
- Staff balancing health and safety of multiple people while administering medications.
- Providers/staff being unaware of medication changes (e.g. staff did not read the MAR; medication changes were not shared among staff).

IV. Considerations for recommendation

2023 considerations

Three regional quality council workgroups reviewed data from 25 critical incident reviews related to service terminations and/or suspensions and medication errors, identified systemic barriers or challenges, and proposed considerations for systemic change to better support lead agencies, providers, and/or people who receive services. Below, are the six recommended considerations from the 2023 review period that might improve outcomes of critical incidents within different levels of disability services. Under each consideration, there are explanations supporting the need for change and the status of the consideration. Additionally, the workgroups identified key learnings, or points of interest, that might inform future outcomes and improvements within other areas of disability services.

Considerations related to service terminations and/or suspensions

Consideration 1:

To better support people with complex needs, a reduction or consolidation of paperwork requirements for people who receive services is necessary to allow for individualized support planning to meet the needs of the person and reduce the possibility of service terminations and/or suspensions.

- Support planning meetings require a high volume of paperwork, which might limit the opportunity for conversations to learn about the person and how to best meet their service needs.
- People who receive services are often required to complete forms that appear redundant or have repeated questions across service types, which might cause increased anxiety, frustration and challenging behavior. Reducing or consolidating redundant or high-volume paperwork where possible, such as person-centered plans, support plans, individual abuse prevention plans and service provider admission/intake process, might reduce undesired outcomes.
- An online portal or software program might allow for a person's information to be stored securely and shared among designated service providers, lead agency staff and other approved professionals.

Consideration status: Paperwork reduction and systems improvement analysis is an ongoing effort across DHS. DSD continues to evaluate how reducing paperwork in 245D-licensed facilities affects providers and people who receive services. During the next review period, DSD will continue to facilitate discussions about this consideration between departments and division leadership.

Key learnings related to service terminations and/or suspensions:

- Property damage by a person who receives services might affect a provider's ability to serve people with complex needs and aggression as costs associated with property damage are not reimbursed under waived services, except for modifications that protect the property from future damage.
- When direct care staff contact emergency services for "non-emergency" incidents involving a person with complex needs and aggression, law enforcement and emergency services might not respond, which affects the provider's ability to access support.
- Continued collaboration between lead agencies, law enforcement and emergency services are necessary to support people with varied needs related to disability, mental health, substance use and/or crisis.
- Challenges exist when aligning staffing ratios with the needs of the person and the capacity of the providers.
- Over the past few years, support planning teams experienced difficulties collaborating regularly as team members had more responsibilities and increased virtual meetings, which further affected their availability and access/knowledge of technology to join the virtual meetings.

Considerations related to medication errors

Consideration 2:

A legislative proposal should be developed to edit the [DHS 6790 form](#) (including a fiscal note) to add medication administration as a value and information needed to establish a rate in the Rate Management System.

- Medication administration is imperative to people who receive services and requires a lot of time, focus and attention. Providers and direct care staff are often balancing many duties and tasks during medication management and administration.
- The reimbursement rate providers receive for training might not meet the demands and challenges for training and support around medication administration. Rates may be adjusted according to the level of complexity of the required medication administration.
- Staffing shortages affect providers' capacity to offer medication administration training on a continuous basis when trained staff leave and new staff are hired.

Consideration status: DSD understands how complex the medication administration process can be for staff working in home and community-based settings. At this time we are not pursuing a legislative proposal, but DSD will continue to discuss the complexities of medication administration, and how this affects providers, with relevant business areas.

Consideration 3:

When people with disabilities (who are on a Minnesota health care program) are hospitalized, they should have access to all services and supports (e.g. disability services provider). Providers should be allowed to bill while a person is in the hospital to provide ongoing support and coordinate discharge back to the person's home.

- A person's health care program (e.g. waiver) pausing while in the hospital creates barriers. In a moment of need, concern and crisis, our system should support stabilizing services for people and have clear roles (e.g. case manager, provider, hospital) for the people who support them.
- A person's plan and medical information across roles/organizations does not share or transfer information easily. Providers might miss out on gathering information about new/changed medications since they are not directly involved with the care and/or discharge while the person who receives services is in the hospital. This gap increases the need to have providers present to support and communicate with hospital staff.
- Providers maintaining support for a person in a hospital might affect the person's overall wellness and improve the continuity of care by supporting the communication between the person and medical providers about service needs and planning for transition/discharge.

Consideration status: This was part of a 2024 proposal to expand home and community-based hourly services and to modify state plan services; however, DHS is still working to determine how to implement this change. DSD will continue to share this consideration with relevant business areas.

Consideration 4:

Add specific language to the [Community-Based Services Manual \(CBSM\)](#) that considers assistive technology for medication management and administration a covered waiver service.

- There is conflicting information about what costs the waiver will cover to support people with medication management and/or administration. For example, if a facility has nursing staff, the waiver might not pay for an automated medication dispenser.
- On the [assistive technology CBSM page](#), information and language about assistive technology related to medication management and administration is not available.
- Increasing awareness and access to assistive technology for medication management and administration might create a more efficient system with fewer medication errors and possible reduction on the reliance of staff.

Consideration status: Minnesota continues to work toward becoming a Technology First state. DSD will continue to research and evaluate any challenges to a person's ability to use assistive technology to administer prescribed medications. Other related efforts include the [Assistance technology resource guide](#) (2023) and [SEMCIL Assistive Technology Lab](#).

Consideration 5:

DHS creates and offers a standard training on best practices for medication administration.

- According to the number of systemic critical incidents reviewed by DHS, medication errors are a common incident type. Through the reviews, DHS discovered that providers used a variety of training methods to support medication administration according to their policies and procedures, but there was no standardized training that aligned with [Minnesota Statutes, section 245D.05](#) licensing requirements for medication administration.
- The creation of a standardized medication administration training offered by DHS might reduce medication errors as providers would adhere to best practices rather than deferring to their own policies and procedures.

Consideration status: Through research, DHS determined some medication administration training courses are available for purchase through external agencies. Providers may contract with outside agencies to provide medication administration training or use the College of Direct Support. In addition, the recently updated [Psychotropic Medication Manual](#) offers additional support for medication management and administration. DSD will work with DHS Licensing to review this consideration, as well as other applicable statutes that govern medication administration and training in 245D settings.

Consideration 6:

Find ways to support providers to buy technology to help with medication administration.

- Providers might be using outdated medication management practices that increase the risk of medication errors. The use of technology, such as automated medication dispensers or electronic documentation software, during medication administration might lead to fewer medication errors.
- Not all providers have knowledge or funds available to purchase medication management equipment and technology, so by adding “access to medication equipment/software” in the exception rate for serving someone, the provider might receive additional funding for related resources.

Consideration status: The original consideration included a recommendation to modify the Disability Waiver Rate System (DWRS) exception request process; however, after review, the consideration was broadened so that there were more options to address the intended goal. DSD will continue to have discussions with relevant business areas.

Key learnings related to medication errors:

- There is a continued need to study and learn more about medication error incident types to identify additional systemic barriers and challenges and propose considerations for systemic change to better support lead agencies, providers and/or people who receive services.
- Communication challenges exist between providers and medical professionals.
- Because of staffing shortages or increased responsibilities, there might be limited time to share imperative health or medication changes with other staff; or staff might not be aware of what tasks to prioritize, such as medication administration.
- Further exploration of the cost and impact of undelivered care following a medication error, such as hospitalizations, medical appointments, treatment/recovery, investigations, etc. might inform additional systemic barriers and challenges.

Summary of 2022 considerations and status updates

Throughout the course of the 2023 review period, DHS shared the identified considerations and key learnings, along with consideration updates from the [2022 Annual Report](#) with internal and external partners within disability services to explore existing efforts that promote internal systems and/or legislative change to reduce critical incidents and support people who receive services and service providers. This holistic approach acknowledges how systemic themes are influenced by barriers and challenges that exist across different levels of disability services and what considerations might promote a proactive response to critical incident outcomes and ultimately reduce the prevalence of critical incident types. DSD strives to ensure that each consideration is communicated to the appropriate internal departments, although it might delay the ability to provide adequate status updates because of staff promotion and transfers, position vacancies and staff departures. Since the last annual report, DSD has evaluated current standard operating procedures and established goals for the next review period to enhance Culture of Safety work within the division, including:

1. Review key learnings and systemic themes from each critical incident review with the regional quality councils, with the intent to create considerations that are framed in actionable ways.
2. Work to better understand the barriers identified within each consideration to develop solutions within the scope of disability services.
3. Create a cross divisional workgroup, or safety action workgroup, by summer 2025 to review considerations and any identified solutions, provide education on individual policies, use equity analysis tools to inform proposed changes in legislation, review annual report(s) and provide status updates on previous considerations.
4. Evaluate ways to explore additional critical incident types using the various critical incident review models.
5. Evaluate how to address diversity, access and attrition within the roles and workgroups participating in the incident review models.

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ማሳሰቢያ፡- ስለ ዶክመንቱ ነፃ ገለፃ ከፈለጉ፣ ሠራተኛዎን ያነጋግሩ። Amharic

انتباه. إذا احتجت الى مساعدة مجانية في ترجمة هذه الوثيقة، اتصل بالرقم الموجود في المربع أعلاه. Arabic

মেনাযোগ দিন। যিদ আপিন বিনামূলেয এই নিখটিৰ বযাযাৰ জেনয সহায় চান তাহেল উপেকাকত বাকেস থাকা নমবৰটিতে কল করুন। Bengali

သတိပြုရန်။ ဤစာတမ်းကို ဘာသာပြန်ဆိုင်ရန်အတွက် အခမဲ့အကူအညီ လိုအပ်ပါက၊ အထက်ဖော်ပြပါ အကွက်ရှိ နံပါတ်ကို ခေါ်ဆိုပါ။ Burmese

ការយកចិត្តទុកដាក់។ ប្រសិនបើអ្នកត្រូវការជំនួយឥតគិតថ្លៃ ក្នុងការបកស្រាយឯកសារនេះ សូមហៅទូរសព្ទទៅលេខក្នុងប្រអប់ខាងលើ។ Cambodian

注意！如果您需要免費的口譯支持，請撥打上方方框中的電話號碼。 Cantonese (Traditional Chinese)

wán. héčínhan niyé wačínjyAn wayúiyeska ki de wówapi sutá, ečíyA kin wóiyawa ed ophiye wan. Dakota

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સાવધાન. જો તમને આ દસ્તાવેજને સમજવા માટે નિ:શુલ્ક મદદની જરૂર હોય, તો ઉપરના બોક્સ પૈકીના નંબર પર કોલ કરો. Gujarati

ध्यान दें। यदि आपको इस दस्तावेज़ की व्याख्या में निशुल्क सहायता की आवश्यकता है, तो ऊपर बॉक्स में दिए गए नंबर पर कॉल करें। Hindi

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Lus Ceeb Toom. Yog tias koj xav tau kev pab txhais lus dawb ntawm cov ntaub ntawv no, ces hu rau tus nab npawb xov tooj nyob hauv lub npov plaub fab saum toj no. Hmong

ဟ်သုဉ်ဟ်သး. နမ့ၢ်လိာ်ဘဉ် တၢ်မၤစၢၤကလီၤလၢ ကကိၣ်းထံလံာ်တီၢ်မိတဖဉ်အဃိ, ကိးနီၣ်ဂံၢ်လၢ အအိၣ်ဖဲတၢ်လွံၢ်နၢၣ် လၢတၢ်ဖိခိၣ်အပူၤတက့ၢ်. Karen

이 문서의 내용을 이해하는 데 도움이 필요하시면 위에 있는
전화번호로 연락해 무료 통역 서비스를 받으실 수 있습니다. Korean

تکایه سهرنج بده. ئەگەر بۆ وەرگیرانی ئەم بەلگەنامەیە پێویستت بە یارمەتی بێبەرامبەرە، ئەوا
پەڕه‌ندی به‌و ژماره‌یه‌وه بکه که له بۆکسه‌که‌ی سهره‌ودایه. Kurdish Sorani

Baldarî. Ger ji bo wergerandina vê belgeyê hewcedariya we bi alîkariya belaş hebe, ji kerema xwe bi hejmara li qutiya jorîn re telefon bikin. Kurdish Kurmanji

Hoǎpín. Tóhán wanǵí thí wíyukčanpi kin yuhá níyunspe héčha čhéya, lé tkíčhun kin k'é nánpa opáwinyan. Lakota

ເອົາໃຈໃສ່. ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອພຣີໃນການຕີຄວາມເອກະສານນີ້,
ໃຫ້ໃບຫາເປີທີ່ຢູ່ໃນບ່ອງຂ້າງເທິງ. Lao

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Mandarin (Simplified Chinese)

P̄alɛ rɔ piny: Mi gööri luäk lɔrä kɛ luɔɕ kä mɛmɛ, yɔtni nāmbär ɛmɔ tēē
nhial guäth ɛmɛ. Nuer

Mah Biz'sin'dan.

Keesh'pin nan'deh'dam'mun chi'wee'chi'goo'yan chi'nis'too'ta'man
oo'weh ooshii'be'kan.

Ishi'kidoon ah'kin'das'soon ka'ooshi'bee'kadehk ish'peh'mik ka'shi
ka'ka'kak. Ojibwe

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Hubachiisa:-Yoo barreeffama kana hiikuuf gargaarsa bilisaa barbaaddan, lakkoofsa saanduqa armaan olii keessa jirun bilbilaa Oromo

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Pažnja. Ukoliko vam je potrebna besplatna pomoć u tumačenju ovog dokumenta, pozovite broj naveden u kvadratu iznad. Serbian

Fiiro gaar ah. Haddii aad u baahan tahay caawimo bilaash si laguugu turjumo dukumiintigan, wac lambarka ku jira sanduuqa sare. Somali

Atención. Si necesita ayuda gratuita para interpretar este documento, llame al número que aparece en el recuadro superior. Spanish

Zingatia. Iwapo unahitaji msaada usio na malipo wa kutafsiri hati hii, piga simu kwa namba iliyo kwenye kisanduku hapo juu. Swahili

ልቢ በሉ፡ ነዚ ሰነድ ንምትርጓም ነፃ ሓገዝ እንተ ደልዮም፣ በቲ ኣብ ላዕሊ ኣብ ውሽጢ ሰደጃ ተቐሚጡ ዘሎ ቁጽሪ ይደውሉ። Tigrinya

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Àkíyèsí. Tí o bá nílò ìrànlówọ pẹ̀lú tí tú mọ àkòólẹ̀ yìí, pe nọmbà tó wà nínú àpótí tí wà ló kẹ̀. Yoruba



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