INCIDENT MANAGEMENT

The following policies and procedures apply to all programs operated by Shema Kolainu-Hear Our Voices (SKHOV) and operated, certified, sponsored, or funded by OPWDD for the provision of services to persons with developmental disabilities and individuals under the auspices of New York City Department of Mental Health and Hygiene, and New York State Education Department.

The following policies and procedures are intended to:

- Protect individuals from harm.
- Improve the quality of care of the individuals served at SKHOV.
- Ensure that all individuals are free from abuse.
- Identify and correct conditions that may contribute to harm/abuse.
- Prevent the recurrence of incidents.

POLICIES AND PROCEDURES

SKHOV has developed policies and procedures that are in conformance with Part 624 to address:

- Reporting, recording, investigation, review, and monitoring of reportable incidents, notable occurrences and agency occurrences;
- Identification of reporting responsibilities of employees, interns, volunteers, consultants, contractors, and family care providers.

Notification of Incident Policies and Procedures/OPWDD Learning About Incidents Brochure/Part 624 Regulations:

- During the admission process, the individual's intake packet will include information for accessing either in electronic format, or, if requested, in paper copies, a copy of SKHOV's Incident Management Policies and Procedures, the OPWDD Learning About Incidents Brochure and the Part 624 Regulations, to persons receiving services who have the capacity to understand the information and to their parents, guardians, correspondents (from 624.20 regulations) or advocates (from 624.20 regulations), unless a person is a capable adult who objects to their notification.
- Annually thereafter, SKHOV shall provide the means to access this information via letter or email.
- Upon employment or initial volunteer, contract, or sponsorship arrangements, and annually thereafter, SKHOV shall make SKHOV's policies and procedures on incident management known to agency employees, interns, volunteers, consultants, contractors, and family care providers during orientation and annual OPWDD trainings and/or via email.
- In accordance with section 633.7 regulations, custodians with regular and direct contact in facilities and programs operated or certified by OPWDD shall be provided with the code of conduct adopted by the Justice Center.

GENERAL POLICY

All staff regardless of their position is responsible to make every effort to prevent incidents from occurring.

General investigation requirements

- Any report of a reportable incident or notable occurrence (both serious and minor) shall be thoroughly investigated by the chief executive officer or an investigator designated by the chief executive officer, unless OPWDD or the Justice Center advises the chief executive officer that the incident or occurrence will be investigated by OPWDD or the Justice Center and specifically relieves SKHOV of the obligation to investigate or applies restrictions to the investigation.
- Investigations of all reportable incidents and notable occurrences shall be initiated immediately, with further investigation undertaken commensurate with the seriousness and circumstances of the situation.
- SKHOV shall commence an investigation immediately even when it anticipates that the Justice Center or Central Office of OPWDD will assume the responsibility for the investigation. However, if SKHOV can reasonably anticipate that the Justice Center or the Central Office of OPWDD are likely to investigate the incident, the actions taken by SKHOV are restricted to:
    - Securing and/or documenting (e.g. photographing) the scene as appropriate;
    - Collecting and securing physical evidence;
    - Taking preliminary statements from witnesses and involved parties; and
    - Performing such other actions as specified by the Justice Center or OPWDD.
- In the event that law enforcement directs that SKHOV forgo any actions, SKHOV shall comply with such direction.

- SKHOV is responsible for monitoring IRMA to ascertain whether the Justice Center, the Central Office of OPWDD or SKHOV is responsible for the investigation.
- If the Justice Center or the Central Office of OPWDD is responsible for the investigation, SKHOV shall fully cooperate with the assigned investigator, but shall not conduct an independent investigation, unless approved to do so by the Justice Center or OPWDD.
- Investigations conducted by SKHOV shall incorporate the following:
    - If a person is physically injured, an appropriate medical examination of the injured person shall be obtained. The name of the examiner shall be recorded and his or her written findings shall be retained.
    - For injuries unknown origin, all persons having contact with the individual within 24 hours prior to the discovery of the injury, must be interviewed.
    - Witnesses to the incident or occurrence shall be identified and shall be interviewed in as private an environment as possible.
    - Interviews should be conducted separately by qualified, objective parties. Interviews of individuals receiving services should be conducted by parties with an understanding of the persons' unique needs and/or capabilities.
    - Pertinent information shall be reviewed (e.g., records, photos, observations of incident scene, expert assessments).
    - Physical evidence, if any, shall be identified and appropriate steps shall be taken to safeguard and preserve physical evidence.
    - Body checks will be conducted, when needed, to identify any injuries that may have been inflicted upon the individual which would assist in determining medical follow up.
- All incidents are to be thoroughly investigated and an incident report completed noting any immediate corrective actions. All appropriate parties are to be interviewed, including persons receiving services, and statements taken. Furthermore, medical information and evidence is to be gathered as applicable, and the conclusion of the investigation is to be noted with recommendations/corrective actions indicated.
- When an incident occurs, the staff member who observed or discovered the incident is responsible for protecting the individual from further harm, providing necessary treatment, implementing immediate corrective actions, call for assistance if needed and notify a supervisor.
- Where applicable, all involved programs at SKHOV are responsible to communicate with each other to ensure that accurate classification, reporting, investigating, and follow-up takes place.
- Any party who has been assigned to investigate a reportable incident, or notable occurrence in which he or she recognizes a potential conflict of interest in the assignment, shall report this information to SKHOV. SKHOV shall relieve the assigned investigator of the duty to investigate if it is determined that there is a conflict of interest in the assignment.
- No one may conduct an investigation of any reportable incident or serious notable occurrence in which he or she was directly involved, in which his or her testimony is incorporated, or in which a spouse, domestic partner, or immediate family member was directly involved.
- For reportable incidents or serious notable occurrences which occurred on or after June 30, 2013, no one may conduct an investigation in which his or her spouse, domestic partner, or immediate family member provides supervision to the program where the incident took place or provides supervision to directly involved parties.
- Members of an incident review committee (IRC) shall not routinely be assigned the responsibility of investigating incidents or occurrences. In the event that an IRC member conducts an investigation of an incident or occurrence, SKHOV shall comply with subparagraph 624.7(d)(7)(ii) of the regulations.

For reportable incidents and serious notable occurrences:

- SKHOV shall assign an investigator whose work function is at arm's length from staff who are directly involved in the reportable incident or serious notable occurrence.
- No party in the direct line of supervision of staff who are directly involved in the reportable incident or serious notable occurrence may conduct the investigation of such an incident or occurrence, except for the chief executive officer.
- Although the chief executive officer is in the direct line of supervision of all staff, the chief executive officer (not a designee) may conduct the investigation of a reportable incident or serious notable occurrence unless he or she is the immediate supervisor of any staff who are directly involved in the reportable incident or serious notable occurrence.
- When an incident or occurrence is investigated or reviewed by OPWDD and OPWDD makes recommendations to SKHOV concerning any matter related to the incident or occurrence (except during survey activities), SKHOV shall either:
    - Implement each recommendation in a timely fashion and submit documentation of the implementation to OPWDD; or
    - In the event that SKHOV does not implement a particular recommendation, submit written justification to OPWDD, within a month after the recommendation is made, and identify the alternative means that will be undertaken to address the issue, or explain why no action was needed.

- When the Justice Center makes findings concerning matters referred to its attention and the Justice Center issues a report and recommendations to SKHOV regarding such matters, SKHOV will make a written response, within ninety days of receipt of such report, of action taken regarding each of the recommendations in the report.
- Each program will file their incident reports and investigations in a confidential manner.
- For significant incidents, serious notable occurrences and for allegations of abuse, the Quality Assurance Department is responsible to report the incident to applicable outside parties and to investigate the situation.
- During the weekends, holidays and after 5pm on weekdays, a member of the Quality Assurance Department will be on call to notify IMU of all serious notable occurrences, significant incidents, and allegations of abuse. The on-call number is 718-686-9600. The appropriate program will be responsible to provide all required documentation to the QA on call staff. In the event that the on-call person cannot be reached, staff must call other quality assurance staff until one is contacted.
- When an individual is involved in an incident involving more than one program within SKHOV, (e.g. injury sustained at the residence and reported/discovered at the day habilitation program), the program where the incident took place will be responsible to document the incident report, the 148 report, the Jonathan's Law forms, where applicable.
- When an individual is involved in an injury of unknown origin, the program that discovered the injury is responsible to document the incident report and make notifications. The discovering program will also conduct an investigation and collaborate with the other program to complete the investigation. For injuries unknown origin, all persons having contact with the individual within 24 hours prior to the discovery of the injury, must be interviewed.
- When an incident occurs while an individual is still directly under the auspices of SKHOV, but is not physically at the facility (e.g., in a restaurant, at the doctor, visiting family, in school, on a vacation trip, receiving non-certified services at a non-certified location), SKHOV will still be responsible to report, document and investigate the situation.

Duty to report events or situations under the auspices of another agency:

(1) If a reportable incident or notable occurrence is alleged to have occurred while a person was under the auspices of another agency (e.g., day habilitation staff allege that a situation occurred at a residence), the discovering agency will be responsible to document the situation and report the situation to the agency under whose auspices the event or situation occurred. The discovering agency is not required to document the incident report. The agency where the incident took place will document the incident report, the 148 report, Jonathan's Law forms, where applicable, and investigate the situation.
(2) Note that mandated reporters (e.g. custodians) are required to make reports to the VPCR pursuant to section 491 of the social services law. The mandated reporters at the discovering agency must report to the VPCR upon discovery of a reportable incident that occurred in another program or facility which is certified or operated by OWPDD.
(3) It will be the responsibility of the agency under whose auspices the situation is alleged to have occurred, to report, investigate, review, correct, and monitor the situation.
Note: Similarly, when a person receives two or more services from the same provider agency, and one program or service environment discovers an incident that is alleged to have occurred under the supervision of another program or service environment operated by the same agency, the discovering program/service environment must document the situation and report it to the program/service environment where the situation or event is alleged to have occurred. The program or service environment where the incident is alleged to have occurred is responsible for reporting and managing the incident, in accordance with the regulation and agency policy.
(4) If the agency suspecting or alleging the incident or occurrence is not satisfied that the situation will be or is being investigated or handled appropriately, it will bring the situation to the attention of OPWDD.

When an incident occurs at an individual's private home, the agency responsible for intervening shall be the provider of the services to the individual (or sponsoring agency) in the order stated:

(i) Residential facility, including a family care home (note: this does not include free-standing respite facilities);
(ii) certified day program (if the individual is receiving services from more than one certified day program, the responsible agency shall be SKHOV that provides the greater duration of service on a regular basis);
(iii) MSC or PCSS;
(iv) HCBS Waiver services including respite services provided at a free standing respite facility or services under the Care at Home Waiver;
(v) FSS, ISS and/or Article 16 clinic services;
(vi) Any other service certified, operated, or funded by OPWDD.

For individuals who receive any type of OPWDD services, an OPWDD 147 incident report will be documented for minor notable occurrences, serious notable occurrences, significant incidents and allegations of abuse.

For individuals who do not receive OPWDD services, an Education NYC/ASP incident report will be documented for minor notable occurrences, serious notable occurrences, significant incidents and allegations of abuse.

The reporting practices for an incident requiring an Education NYC/ASP incident report are the same as incidents requiring a OPWDD 147 incident report, however for Education NYC/ASP incident reports, documentation will be kept internally since no outside agencies are contacted (IMU, MHLS, etc.).

Regardless if the investigation has been completed, the incident report will be submitted for review at the next scheduled Incident Review Committee meeting.

When a possible crime has been committed (i.e. possible criminal act, sexual abuse, physical abuse, etc.) SKHOV must contact law enforcement officials as soon as possible, but no later than 24 hours from the occurrence/discovery. Upon the request of law enforcement officials, SKHOV might need to defer some or all of its investigative activities.

Records and statistics.

(1) Record retention. SKHOV will retain its records pertaining to incidents and occurrences as follows:

- Records will be retained that include evidence and materials obtained or accessed during the investigative process, copies of all documents generated in accordance with requirements of the regulation, and documentation regarding compliance with the requirements of the regulation.
- SKHOV will retain investigative records for seven years from the date that the incident or allegation of abuse is closed. However, when there is a pending audit or litigation concerning an incident or allegation of abuse, agencies shall retain the pertinent records during the pendency of the audit or litigation.

(2) Records, reports, and documentation shall be retrievable by the person's name and filing number or identification code assigned by SKHOV (See: Agency Incident Number Guide). For incidents and occurrences which are reported in IRMA, such information shall be retrievable by the master incident number in IRMA.

(3) When there is an incident or occurrence reported involving more than one person receiving services:

- From a statistical point of view, the situation will be considered as one event and shall be recorded as such.
- SKHOV will establish procedures it deems necessary to ensure that overall statistics reflect single events and that, when an event involves more than one person, records are retrievable by event in addition to being retrievable by a person's name.

(4) Confidentiality of records. All records generated in accordance with the requirements of Part 624 will be kept confidential and shall not be disclosed except as otherwise authorized by law or regulation. Records of reportable incidents that are reported to the Justice Center are to be kept confidential pursuant to section 496 of the Social Services Law.

Reporting to law enforcement.

- An appropriate law enforcement official must be contacted immediately in the event that an emergency response by law enforcement is needed.
- Agencies shall report to an appropriate law enforcement official anytime a crime may have been committed against an individual by a custodian. This is in addition to reporting to the Justice Center when the event or situation is a reportable incident (if the services are certified by OPWDD).
- The report to the appropriate law enforcement official shall be made as soon as practicable, but in no event later than 24 hours after occurrence or discovery of the incident.
- Information about the report to the appropriate law enforcement official shall be entered into IRMA within 24 hours of the report being made.

In a case where a subject of a report of alleged abuse or neglect resigns from his or her position or is terminated while under investigation, SKHOV will promptly report such resignation or termination to the Justice Center. The subject of a report means a custodian who is reported to the VPCR for the alleged abuse or neglect of a person receiving services.

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Classifications of Incidents: (Agency Occurrences, Minor Notable Occurrences, Serious Notable Occurrences, Significant Incidents & Allegations of Abuse)

CLASSIFICATIONS

AGENCY OCCURRENCES (Internal SKHOV Forms)	MINOR NOTABLE OCCURRENCE (OPWDD 147)	SERIOUS NOTABLE OCCURRENCE (OPWDD 147)
INJURY Any injury requiring only first aid treatment, even if the treatment is provided by a doctor (e.g. hot/cold compress, bandage, controlling bleeding, etc.). *An illness is not an injury (e.g. seizure, Psychiatric evaluation/admission, etc.).*	**INJURY** Any suspected or confirmed harm, hurt, damage to an individual receiving services which results in the individual requiring medical or dental treatment by a physician, dentist, physician's assistant or nurse practitioner, and such treatment is more than first aid (e.g. stitches, "positive x-ray"- such as for a broken/fractured bone, prescribed antibiotics, etc.). *An illness is not an injury (e.g. seizure, psychiatric evaluation/admission, etc.)*	**INJURY** An injury that results in the admission of a person to a hospital or 24-hour infirmary for treatment or observation because of the injury. *An illness is not an injury (e.g. seizure, psychiatric evaluation/admission, etc.)*
SUSPECTED THEFT OR FINANCIAL EXPLOITATION Any suspected theft or financial exploitation of a service recipient's personal property that is less than or equal to $15.00 in replacement value, that does not involve a debit, credit, or public benefit card, and that is an isolated occurrence.	**SUSPECTED THEFT OR FINANCIAL EXPLOITATION** Any suspected theft or financial exploitation of a service recipient's personal property that is more than $15.00 and less than or equal to $100.00 in replacement value, that does not involve a debit, credit, or public benefit card, and that is an isolated occurrence.	
MEDICATION ERROR A situation in which an error in medication administration or documentation occurs and there are no marked adverse effects or jeopardy to health or welfare. Medication errors include: <u>Non-Procedural Errors</u>- wrong medication, at the wrong time, wrong dosage, wrong route, wrong individual, or failing to give medication, etc. <u>Procedural Errors</u>- documentation errors.		
		DEATH All loss of life, regardless of cause.
		SENSITIVE SITUATION A situation, not covered by other incident categories, which may be of a delicate nature to SKHOV, and may include possible criminal acts committed by the service recipient.

SIGNIFICANT INCIDENTS-(Documented on the OPWDD 147)

Significant Incidents: An incident, other than an incident of abuse or neglect, that because of its severity or the sensitivity of the situation may result in, or has the reasonably foreseeable potential to result in, harm to the health, safety or welfare of a person receiving services and shall include but shall not be limited to:	
Conduct Between Persons Receiving Services that would Constitute Abuse.	Any conduct between individuals receiving services that would otherwise be considered abuse (see "What is ABUSE/NEGLECT?" section).
Conduct on the part of a custodian that is inconsistent with a service recipient's individual treatment plan, or individualized educational program, generally accepted treatment practices, and/or applicable federal or state laws, regulations or policies, and which impairs or creates a reasonably foreseeable potential to impair the health, safety, or welfare of an individual receiving services, including but not limited to the following:	a. *Seclusion,* which shall mean the placement of a person receiving services in a room or area from which he or she cannot, or perceives that he or she cannot, leave at will. OPWDD prohibits the use of seclusion. b. *Unauthorized use of time – out,* which shall mean the use of a procedure in which a person receiving services is removed from regular programming and isolated in a room or area for the convenience of a custodian, or as a substitute for programming but shall not include the use of a time – out as an emergency intervention to protect the health or safety of the individual or other persons. c. *Administration of a prescribed or over-the-counter medication, which is inconsistent with a prescription or order issued for a service recipient by a licensed qualified health care practitioner, and which has an "adverse effect" on a service recipient.* For the purposes of this paragraph, "adverse effect" shall mean the unanticipated and undesirable side effect from the administration of a particular medication which unfavorably affects the well-being of a service recipient. d. *Inappropriate use of restraints,* which shall mean the use of a restraint when the technique that is used, the amount of force that is used, or the situation in which the restraint is used is inconsistent with an individual's plan of services (including a behavior support plan), generally accepted treatment practices, and/or applicable federal or state laws, regulations or policies. For the purposes of this subdivision, a "restraint" shall include the use of any manual, pharmacological or mechanical measure or device to immobilize or limit the ability of a person receiving services to freely move his or her arms, legs or body. e. *Mistreatment*, other conduct on the part of a custodian, inconsistent with the individual's plan of services, generally accepted treatment practices, and/or applicable federal or state laws, regulations, or policies, and that impairs or creates a reasonably foreseeable potential to impair the health, safety, or welfare of an individual receiving services, except as described in any other provision of this subdivision.
Missing Person at risk of injury	The unexpected absence of an individual receiving services that based on the person's history and current condition exposed him or her to risk of injury.
Unauthorized Absence	The unexpected or unauthorized absence of a person after formal search procedures have been initiated by SKHOV, reasonable judgments, taking into consideration the person's habits, deficits, capabilities, health problems, etc., shall determine when formal search procedures need to be implemented. It is required that formal search procedures must be initiated immediately upon discovery of an absence involving a person whose absence constitutes a recognized potential danger to the well-being of others.
Choking, with Known Risk	Partial or complete blockage of the upper airway by an inhaled or swallowed foreign body, including food, that leads to a partial or complete inability to breathe involving an individual with a known risk for choking and a written directive addressing that risk.
Choking, with No Known Risk	Partial or complete blockage of the upper airway by an inhaled or swallowed foreign body, including food that leads to a partial or complete inability to breathe involving an individual with no known risk for choking.
Self-Abusive Behavior, with Injury	A self-inflicted injury to an individual receiving services that requires medical care beyond first aid.
Injury, with hospital admission	An injury that results in the admission of a service recipient to a hospital for treatment or observation, except as defined as self-abusive behavior with injury.
Theft and Financial Exploitation	Any suspected theft or financial exploitation of a service recipient's personal property that is more than $100.00 in replacement value and/or involves a debit, credit, or public benefit card, regardless of the amount, or that is a pattern of theft.
Other Significant Incident	An incident that occurs under the auspices of an agency, but that does not involve conduct on part of a custodian, and does not meet the definition of any other incident described above, but that because of its severity or the sensitivity of the situation may result in, or has the reasonably foreseeable potential to result in, harm to the health, safety, or welfare of a person receiving services.

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Categories and Definitions of Abuse-(Documented on the OPWDD 147)

"Physical abuse," which shall mean conduct by a custodian intentionally or recklessly causing, by physical contact, physical injury or serious or protracted impairment of the physical, mental or emotional condition of a service recipient or causing the likelihood of such injury or impairment. Such conduct may include but shall not be limited to: slapping, hitting, kicking, biting, choking, smothering, shoving, dragging, throwing, punching, shaking, burning, cutting or the use of corporal punishment. Physical abuse shall not include reasonable emergency interventions necessary to protect the safety of any person.
"Sexual abuse," which shall mean any conduct by a custodian that subjects a person receiving services to any offense defined in article 130 or section 255.25, 255.26 or 255.27 of the penal law (incest); or any conduct or communication by such custodian that allows, permits, uses or encourages a service recipient to engage in any act described in articles 230 or 263 of the penal law (prostitution and sexual performance by a child). Any sexual contact between an individual receiving services and a custodian. For purposes of this paragraph only, a person with a developmental disability who is or was receiving services and is also an employee or volunteer of a service provider shall not be considered a custodian if he or she has sexual contact with another service recipient who is a consenting adult who has consented to such contact.
"Psychological abuse," which shall mean any conduct by a custodian intentionally or recklessly causing, by verbal or non – verbal conduct, a substantial diminution or causing the likelihood of such diminution, of a service recipient's emotional, social or behavioral development or condition, supported by a clinical assessment performed by a physician, psychologist, psychiatric nurse practitioner, licensed clinical or master social worker or licensed mental health counselor (See 624 Handbook, Appendix 1). Such conduct may include but shall not be limited to intimidation, threats, the display of a weapon or other object that could reasonably be perceived by a service recipient as a means for infliction of pain or injury, in a manner that constitutes a threat of physical pain or injury, taunts, derogatory comments or ridicule.
"Deliberate inappropriate use of restraints," which shall mean the use of a restraint when the technique that is used, the amount of force that is used or the situation in which the restraint is used is deliberately inconsistent with a service recipient's individual treatment plan or behavioral intervention plan, generally accepted treatment practices and/or applicable federal or state laws, regulations or policies, except when the restraint is used as a reasonable emergency intervention to prevent imminent risk of harm to a person receiving services or to any other person. For purposes of this subdivision, a "restraint" shall include the use of any manual, pharmacological or mechanical measure or device to immobilize or limit the ability of a person receiving services to freely move his or her arms, legs or body.
"Use of aversive conditioning," which shall mean the application of a physical stimulus that is intended to induce pain or discomfort in order to modify or change the behavior of a person receiving services in the absence of a person – specific authorization by the operating, licensing or certifying state agency pursuant to governing state agency regulations. Aversive conditioning may include but not limited to, the use of physical stimuli such as noxious odors, noxious tastes, blindfolds, the withholding of meals and the provision of substitute foods in an unpalatable form and movement limitations used as punishment, including but not limited to helmets and mechanical restraint devices.
"Unlawful use or administration of a controlled substance," which shall mean any administration by a custodian to a service recipient of; a controlled substance as defined by article thirty – three of the public health law, without a prescription; or other medication not approved for any use by the federal food and drug administration. It also shall include a custodian unlawfully using or distributing a controlled substance as defined by article thirty - three of the public health law, at the workplace or while on duty.
"Neglect," which shall mean any action, inaction or lack of attention that breaches a custodian's duty and that results in or is likely to result in physical injury or serious or protracted impairment of the physical, mental or emotional condition of a service recipient. Neglect shall include, but is not limited to: (i) failure to provide proper supervision, including a lack of proper supervision that results in conduct between persons receiving services that would constitute abuse as described in paragraphs (a) through (g) of this subdivision if committed by a custodian; (ii) failure to provide adequate food, clothing, shelter, medical, dental, optometric or surgical care, consistent with the rules or regulations promulgated by the state agency operating, certifying or supervising the facility or the provider agency, provided that the facility or provider has reasonable access to the provision of such services and that necessary consents to any such medical, dental, optometric or surgical treatment have been sought and obtained from the appropriate individuals; or (iii) failure to provide access to educational instruction, by a custodian with a duty to ensure that an individual receives access to such instruction in accordance with the provisions of part one of article 65 of the education law and/or the individual's individualized education program.
"Obstruction of reports of "reportable" incidents (abuse/neglect and significant incidents)," which shall mean conduct by a custodian that impedes the discovery, reporting or investigation of the treatment of a service recipient by falsifying records related to safety, treatment or supervision of a service recipient, actively persuading a mandated reporter from making a report of a reportable incident (abuse/neglect & significant incidents) to the statewide vulnerable persons' central register with the intent to suppress the reporting of the investigation of such incident, intentionally making a false statement or intentionally withholding material information during an investigation into such a report; intentional failure of a supervisor or manager to act upon such a report in accordance with governing state agency regulations, policies or procedures; or, for a custodian who fails to report abuse/neglect & significant incidents upon discovery.

INCIDENT NOTIFICATIONS

Agency Occurrences

- Shall be reported to the director of the program within 48 hours upon occurrence or discovery.

Minor Notable Occurrences

- Shall be reported to the chief executive officer or designee within 48 hours upon occurrence or discovery.

Serious Notable Occurrences

- Shall be reported to the chief executive officer/designee and Quality Assurance Dept. immediately upon occurrence or discovery.
- Shall be reported to OPWDD immediately:
    - During Business Hours: by calling the IMU Incident Compliance Officer.
    - After Business Hours:
        - If the incident not egregious or sensitive in nature, either leave a message on the Incident Compliance Officer's voicemail or email the required information to OPWDD.Incident.Notifications@opwdd.ny.gov
        - If the incident is egregious or sensitive in nature, call the IMU Hotline at 1-888-479-6763.

Significant Incidents

- Shall be reported to the chief executive officer/designee and Quality Assurance Dept. immediately upon occurrence or discovery.
- Shall be reported to OPWDD immediately:
    - During Business Hours: by calling the IMU Incident Compliance Officer.
    - After Business Hours:
        - For all Deaths or if the incident is egregious or sensitive in nature, call the IMU Hotline at 1-888-479-6763.
        - If the incident not egregious or sensitive in nature, either leave a message on the Incident Compliance Officer's voicemail or email the required information to OPWDD.Incident.Notifications@opwdd.ny.gov
- Custodians in programs or facilities certified by OPWDD shall submit reports of significant incidents to the VPCR immediately upon discovery of the incident via the VPCR Hotline at 1-855-373-2122.

Allegations of Abuse

- Shall be reported to the chief executive officer/designee and Quality Assurance Dept. immediately upon occurrence or discovery.
- Shall be reported to OPWDD immediately:
    - During Business Hours: by calling the IMU Incident Compliance Officer.
    - After Business Hours: by calling the IMU Hotline at 1-888-479-6763.
- Custodians in programs or facilities certified by OPWDD shall submit reports of allegations of abuse to the VPCR immediately upon discovery of the incident via the VPCR Hotline at 1-855-373-2122.

Reporting to OPWDD

Reporting using the OPWDD Incident Report and Management Application (IRMA)

Information shall be entered into IRMA by QA staff for the following:

- Allegations of Abuse, Significant Incidents and Serious Notable Occurrences.

Reporting initial information in IRMA

- Initial information is information about the incident or occurrence that is required to create a new

incident report in IRMA and any other information available at the time when information is first entered into IRMA (see Incident Report and Management Application (IRMA) section).

When a report of allegation of abuse, Significant Incident or a Serious Notable Occurrence is made to the Vulnerable Persons Central Register (VPCR):

- initial information is automatically entered into IRMA by the Justice Center; however,
- The QA department is required to review the information within 24 hours of occurrence or discovery or by close of the next working day, whichever is later, and to report missing or discrepant information to OPWDD.

When a report of a reportable incident or a serious notable occurrence is not made to the VPCR, initial information shall be entered into IRMA by QA staff within 24 hours of occurrence or discovery or by close of the next working day, whichever is later.

Policy & Procedure on Ensuring Reports of Reportable Incidents Are Made to the Justice Center:

Policy

All custodians employed by SKHOV are mandated reporters and are therefore required to report reportable incidents (significant incidents & allegations of abuse) that take place in a certified facility to the Vulnerable Persons' Central Register (VPCR).

Procedure

All custodians employed at SKHOV are responsible to immediately report all incidents to their immediate supervisors upon discovery of an incident in order to immediately implement protections to ensure the individual's health & safety. Protections may include, but are not limited to, separating the suspect of an allegation from contact with any individuals, ensuring appropriate medical treatment, etc.

When the incident is a reportable incident which takes place in a certified facility at SKHOV, the staff discovering/observing the incident is required to call in the incident to the VPCR (1-855-373-2122) and retrieve the Justice Center Identifier number (101-XXXXXX).

The program supervisor will obtain verbal conformation from the caller that the notification was made and provide the supervisor with the Justice Center Identifier number (101-XXXXXX).

The Quality Assurance Department will monitor IRMA to ensure that the call was made. If the incident is not found in IRMA, the Quality Assurance Department will notify the program supervisor to call the incident to the VPCR.

INCIDENT REPORT AND MANAGEMENT APPLICATION (IRMA)
(For Abuse/Neglect, Significant Incidents & Serious Notables)

Agency Initial Incident Process:

- When an incident appears on Justice Center (JC) tab of IRMA because a file has been transmitted by the JC, go into the edit page of incident.
- QA staff will enter information as appropriate for initial information and any information from Justice Center xml file if needed to complete required fields in IRMA. **Please note SKHOV must complete information in IRMA as has historically been required. This includes a concise and

clear description of the incident reported to SKHOV, contributing factors, immediate protections, additional steps taken and pertinent notifications.

- When all required information has been entered
  - Find and select the Program Site on drop down menu
  - Find location where the incident occurred on the drop down menu
  - Ensure date and time of incident are correct
  - Move to Individual tab
  - Click on Change Category/ Classification
  - If category in IRMA is-
    a) abuse/ neglect or significant incident that was selected by the Justice Center;
       i. If the category is correct; no action is necessary.
       ii. If the Category is incorrect please make a note of the MIN number and send to the IMU compliance officer for follow up with Justice Center.
       iii. Submit when completed.
- If the incident category is Non NYJC Non-Reportable, QA staff will make a determination to whether the report is an incident that should be reported in the notable occurrence category or if it falls under Part 625.
  i. If it should be reported as a notable occurrence, select the appropriate category and classification from the drop down box
  ii. If an Event/Situation that should be filed under Part 625, select that option
  iii. Select the Individual from the drop down box,
    a) If the individual is not listed then the program selected is most likely not entered correctly
    b) If there are additional individuals involved, they can be added at this screen.
  iv. Submit when completed.
  v. The rest of the Tabs should be completed as they always have been.

  c. If the incident is not an allegation of abuse or significant incident as determined by the Justice Center or is Non NYJC Non-Reportable that should be filed under the notable occurrence category or Part 625, the report should be deleted. QA staff will request this from the IMU compliance officer.

When these steps have been completed and the investigation delegated, either by the IMU or automatically, the incident will move to the New Incident tab for IMU initial review of all information added by SKHOV, such as initial description, protections, etc.

- Designated information, specified by OPWDD, that is required to be entered into IRMA within 24 hours of the occurrence or discovery, or close of the next working day of the incident, whichever is later, includes the following:
- Incident details tab (page 1 and involved persons page)
- Consumer tab
- Initial findings tab (includes initial findings/preliminary report and immediate protections)
- Notifications tab.
- Other information (IRMA is designed to require the completion of other basic fields for a new incident or allegation of abuse that is entered to be created and a master incident number assigned.)
- Working days are calendar days except for Saturday, Sunday, and public holidays. New York State General Construction

Law Section 22 defines public holidays as: New Year's Day, Dr. Martin Luther King, Jr. Day, Lincoln's Birthday (Feb. 12), President's Day, Memorial Day, Independence Day (July 4), Labor Day, Columbus Day, Veteran's Day, Thanksgiving Day, Christmas Day, and each general election day.

- Subsequent to the initial incident report or allegation of abuse report, information must be entered into IRMA as follows:

Reporting subsequent information in IRMA.

Subsequent information is information concerning the incident or occurrence that is not included in the initial information entered in IRMA. This includes, but is not limited to, information about required notifications that was not reported as part of the initial information and any updates to information related to deaths (e.g. autopsy reports).

Subsequent information shall be entered by the close of the fifth working day after the action is taken or the information becomes available, except as follows:

Subsequent information about immediate protections shall be entered into IRMA within 24 hours after the action is taken or by the close of the next working day, whichever is later.

Subsequent information about a death shall be entered in IRMA within five working days of the discovery of the death, in the manner and form specified by OPWDD.

If another provision of this Part identifies a different timeframe for the entry of specific information, agencies must comply with that timeframe requirement instead. Specific timeframes are identified in provisions concerning:

Reporting updates;

Notification of law enforcement officials (see section 624.6); and

Minutes of incident review committee (IRC) meetings (see section 624.7).

SKHOV is not required to enter information about investigatory activities into IRMA until the investigative report is completed.

For reports of abuse and neglect in facilities and programs that are certified or operated by OPWDD, subsequent information shall include findings and recommendations made by the Justice Center.

Agencies shall comply with all requests by OPWDD for the entry of specific subsequent information.

It is the responsibility of any SKHOV supervisor where a report on a reportable incident or notable occurrence is received or made out, to notify any other agency where the person receives services of that reportable incident or notable occurrence if the incident or occurrence resulted in visible evidence of injury to the person, may be of concern to another agency, or may have an impact upon programming or activities provided by another agency. This notification must be documented on the in initial incident report for that incident.

PROCEDURES FOR AGENCY OCCURRENCES

Injury

- Injuries requiring no more than first aid that occur under the auspices of SKHOV must be documented on an Injury Report or Injury Log/Body Check Sheet and reported to a supervisor. Injuries occurring outside of SKHOV's auspices (i.e. on a home visit, at another program, etc.) must be documented on an Injury of Known Origin Tracking Sheet. For injuries of unknown origin, all persons having contact with the individual within 24 hours prior to the discovery of the injury, must be interviewed.

Medication Error

- Only applies to the Residential, Day Habilitation, and Overnight Respite programs. Medication errors resulting in no adverse side effects must be documented on a Medication Error Report.

Suspected Theft or Financial Exploitation

- Suspected theft or financial exploitation that is less than or equal to $15.00 in replacement value, that does not involve a debit, credit, or benefit card, and that is an isolated occurrence must be documented on a Suspected Theft or Financial Exploitation Incident Report.

Reporting

- The staff person who observed or discovered the incident will immediately notify their immediate supervisor of the situation.
- The supervisor will ensure that the nurse is immediately notified.
- The supervisor will immediately ensure that notifications are made to SKHOV agency management up to the Director of the program or designee within 48 hours of the occurrence or discovery of the incident.
- The supervisor will ensure that all other appropriate notifications are made (i.e. corresponding programs) within 48 hours of the completion of the injury report or medication error report.
- If the individual is taken to the hospital or 24 hour infirmary for the injury, then notification to the parent must be made within 48 hours of the completion of the injury report or medication error report.
- For suspected theft: Law enforcement notification must be made as soon as possible, but no later than 24 hours of the occurrence or discovery of the incident.

Immediate Corrective Action(s)

- It is the responsibility of the staff that observed or discovered the incident to take whatever measures appear to be prudent to ensure the protection of the individual from further injury, harm, or abuse and prompt provision of treatment or care, prior to notifying a supervisor.
- Upon being notified of the incident, it will also be the responsibility of the Director of the program or designee where the incident occurred to take whatever measures appear to be prudent to ensure the protection of the individual from further injury or harm, and prompt provision of treatment or care. Additionally, they will ensure appropriate follow up is implemented which could include, providing counseling, conducting a body check, training pertinent staff, etc.

Investigative Process

- Upon discovery of the incident, the Director of the program or designee will assign an investigator and an investigation will immediately commence.
- For individuals residing in an ICF, the assigned investigator will complete and forward the investigation to the Chief Executive Officer or designee within five working days of the occurrence or discovery of the incident.
- The investigation must be completed within 60 days of the occurrence or discovery of the incident. However, if the investigation is not completed within 60 days, there must be written justification as to why it exceeded 60 days.

Documentation

- The supervisor will ensure that the injury report, the medication error report, or suspected theft report is completed within 48 hours of the occurrence or discovery of the incident.

- For suspected theft: The supervisor will immediately forward the Suspected Theft Report to the IRC Chairperson.
- The supervisor will document all notifications (parent, Care Manager, RN, corresponding programs) within 48 hours of the completion of the injury report or medication error report.
- For suspected theft: The IRC Chairperson will enter the designated information from the Suspected Theft Report into the Incident Report and Management Application (IRMA) within 48 hours of the occurrence or discovery of the incident (see IRMA section below). However, if unable to enter the information into IRMA within 48 hours of the occurrence or discovery due to weekend or holiday, the information may be entered until no later than the close of the next business day (see IRMA section below).
- The supervisor will be responsible to submit the completed and reviewed injury report, the medication error report, or suspected theft report to the Occurrence Incident Review Committee, as soon as possible, but no later than 90 days from the occurrence or discovery of the incident.

Follow- Up

- The injury report, medication error report, or suspected theft report and investigation will be presented to the Occurrence Incident Review Committee for review, as soon as possible, but no later than 90 days from the occurrence or discovery of the incident.
- The case will remain open until all requested information has been submitted to the Occurrence Incident Review Committee chairperson, and the Committee's review of the matter is satisfied.
- If the incident needs to be upgraded to a significant incident, allegation of abuse, minor notable occurrence or serious notable occurrence, staff is to follow the reporting and documentation practices for the appropriate incident classification.
- If upgraded, this incident must then be presented at the next scheduled Agency Wide Incident Review Committee meeting.

PROCEDURES FOR MINOR NOTABLE OCCURRENCES

Reporting

- The staff person who observed or discovered the incident will immediately notify their immediate supervisor of the situation.
- For injuries, the supervisor will ensure that the nurse is immediately notified.
- The supervisor will ensure that notifications are made to SKHOV agency management up to the Chief Executive Officer or designee within 48 hours of the occurrence or discovery of the incident.
- The supervisor will ensure that all other appropriate notifications (family, Care Manager, QIDP, Willowbrook Services Coordinator, corresponding programs, Jonathan's Law) are made within 24 hours of the completion of the OPWDD 147 incident report or Education NYC/ASP incident report. *Please note that for minor notable incidents, the OPWDD 147 must be completed within 48 hours of the occurrence/discovery of the incident or by the end of the next business day, whichever is later.*
- For Willowbrook individuals, the program and the Quality Assurance Department will ensure that all required notifications are made.

Immediate Corrective Action(s)

- It is the responsibility of the staff that observed or discovered the incident to take whatever measures appear to be prudent to ensure the protection of the individual from further injury, harm, or abuse and prompt provision of treatment or care, prior to notifying a supervisor.
- Upon being notified of the incident, it will also be the responsibility of the Director of the program or designee where the incident occurred to take whatever measures appear to be prudent to ensure the protection of the individual from further injury or harm, and prompt provision of treatment or care. Additionally, they will ensure appropriate follow up is implemented which could include, providing counseling, conducting a body check, training pertinent staff, etc.

Investigative Process

- Upon discovery of the incident, an investigator assigned by the Chief Executive Officer will immediately commence an investigation.

- For injuries unknown origin, all persons having contact with the individual within 24 hours prior to the discovery of the injury, must be interviewed.
- For individuals residing in an ICF, the assigned investigator will complete and forward the investigation to the Director of the program or designee within five working days of the occurrence or discovery of the incident.
- The investigation must be completed within 30 days after completion of the OPWDD 147. However, if the investigation is not completed within 30 days, there must be written justification as to why it exceeded 30 days. This justification should be documented in a monthly investigative report.

Documentation

- The supervisor will document the OPWDD 147 incident report or Education NYC/ASP incident report, within 48 hours of the occurrence or discovery of the incident.
- The supervisor will forward the OPWDD 147 incident report or the Education NYC/ASP incident report to the Chief Executive Officer or designee within 48 hours of the occurrence or discovery of the incident.
- For suspected theft: The supervisor will immediately forward the OPWDD 147 incident report to the IRC Chairperson.
- For suspected theft: The IRC Chairperson will enter the designated information from the OPWDD 147 incident report into the Incident Report and Management Application (IRMA) within 48 hours of the occurrence or discovery of the incident (see IRMA section below). However, if unable to enter the information into IRMA within 48 hours of the occurrence or discovery due to weekend or holiday, the information may be entered until no later than the close of the next business day (see IRMA section below).
- The supervisor will document all notifications (parent, Care Manager, RN, corresponding programs) within 24 hours of the completion of the OPWDD 147 incident report or the Education NYC/ASP incident report.
- For Willowbrook individuals, the IRC Chairperson will submit the completed OPWDD 147 incident report to the appropriate Willowbrook representatives.
- The supervisor will submit the completed and reviewed OPWDD 147 incident report or Education NYC/ASP incident report, notifications and investigation to SKHOV Wide Incident Review Committee, as soon as possible, but no later than 90 days from the occurrence or discovery of the incident.

Follow- Up

- The OPWDD 147 incident report or Education NYC/ASP incident report, notifications and the investigation will be presented to SKHOV Wide Incident Review Committee for review, as soon as possible, but no later than 90 days from the occurrence or discovery of the incident. If after 90 days, the incident is still under investigation, an investigative update will be presented. Additional investigative findings will be presented at each meeting until the committee closes the case.
- The case will remain open until all requested information has been submitted to SKHOV Wide Incident Review Committee chairperson, and the Committee's review of the matter is satisfied.
- If the incident needs to be upgraded to a significant incident, serious notable occurrence or an allegation of abuse, staff is to follow the reporting and documentation practices for the appropriate incident classification.
- SKHOV Wide Incident Review Committee Chairperson will forward any findings/recommendations to the Chief Executive Officer or designee within two weeks of each review of the incident.

PROCEDURES FOR SERIOUS NOTABLE OCCURRENCES

Reporting

- The staff person who observed or discovered the incident will immediately notify their supervisor.
- The supervisor will immediately ensure that notifications are made to SKHOV agency management up to the Chief Executive Officer or designee and the Quality Assurance Department.

- The Quality Assurance Department will immediately notify the DDSO of the incident.
- The supervisor will ensure that all other appropriate notifications (parent, Care Manager, corresponding programs, Jonathan's Law) are made within 24 hours of the completion of the OPWDD 147 incident report or Education NYC/ASP incident report.
- For Willowbrook individuals, the program and the Quality Assurance Department will ensure that all required notifications are made.
- When an individual commits a possible criminal act or the individual is a victim of a crime, the Director of the program or designee will ensure that law enforcement have been notified of the incident immediately.
- For injuries, medication errors and death, the supervisor will ensure that the nurse is immediately notified.

Immediate Corrective Action(s)

- It is the responsibility of the staff that observed or discovered the incident to take whatever measures appear to be prudent to ensure the protection of the individual from further injury, harm, or abuse and prompt provision of treatment or care.
- It will be the responsibility of the Director of the program or designee where the incident occurred to take whatever measures appear to be prudent to ensure the protection of the individual from further injury, harm, and prompt provision of treatment or care. Additionally, they will ensure appropriate follow up is implemented which could include, providing counseling, conducting a body check, training pertinent staff, etc.

Investigative Process

- The Quality Assurance Department will immediately begin investigating the incident.
- For injuries unknown origin, all persons having contact with the individual within 24 hours prior to the discovery of the injury, must be interviewed.
- For individuals residing in an ICF, the Quality Assurance Department will complete and forward the investigation to the Chief Executive Officer or designee within five working days of the occurrence or discovery of the incident.
- The investigation must be complete within 30 days of the occurrence or discovery of the incident. However, if the investigation is not completed within 30 days, there must be written justification as to why it exceeded 30 days. This justification should be documented in a monthly investigative report.
- If the investigation is not complete within 30 days, the assigned investigator will be responsible to enter a monthly update into IRMA until the incident is closed.
- The assigned investigator will enter a brief review to the summary of evidence and whatever specific investigatory actions were taken since the last update that was entered into IRMA.
- If there have been no additions to the summary of evidence or investigatory actions taken since the last report, the assigned investigation must specify in IRMA why no progress was made.

Documentation

- The supervisor will document the OPWDD 147 incident report or Education NYC/ASP incident report, excluding notifications, within 24 hours of the occurrence or discovery of the incident.
- The supervisor will immediately forward the OPWDD 147 incident report or Education NYC/ASP incident report to the IRC Chairperson.
- The IRC Chairperson will enter the designated information from the OPWDD 147 incident report, specified by OPWDD, into the Incident Report and Management Application (IRMA) within 24 hours of the occurrence or discovery of the incident (see IRMA section below). However, if unable to enter the information into IRMA within 24 hours of the occurrence or discovery due to weekend or holiday, the information may be entered until no later than the close of the next business day (see IRMA section below). In this event, the OPWDD 147 incident report must be completed and submitted to the IMU within 24 hours of the occurrence or discovery of the incident.

- The supervisor will document all notifications (parent, Care Manager, RN, corresponding programs) within 24 hours of the completion of the OPWDD 147 incident report or the Education NYC/ASP incident report.
- The supervisor will immediately forward the completed notifications to the IRC Chairperson. The IRC Chairperson will then enter this information into IRMA within 24 hours of the occurrence or discovery of the incident.
- For Willowbrook individuals, the IRC Chairperson will submit the completed OPWDD 147 incident report to the appropriate Willowbrook representatives.
- The IRC Chairperson will submit the completed OPWDD 147 incident report or Education NYC/ASP incident report, notifications and investigation to SKHOV Wide Incident Review Committee within 30 days of the occurrence or discovery of the incident.

Follow-Up

- The OPWDD 147 incident report or Education NYC/ASP incident report, notifications, and the investigation will be presented to SKHOV Wide Incident Review Committee for review within 30 days of the occurrence or discovery of the incident. If after 30 days, the incident is still under investigation, an investigative update will be presented. Additional investigative findings will be presented at each meeting until the committee closes the case.
- The case will remain open until all requested information has been submitted to SKHOV Wide Incident Review Committee chairperson, and the Committee's review of the matter is satisfied.
- Within 30 days of the occurrence or discovery of the incident, the IRC Chairperson will enter the final investigation into IRMA. If the investigation is not completed within 30 days, the IRC Chairperson will keep IMU informed in writing, through IRMA, of the progress of the investigation every 30 days until the investigation is completed.
- If the incident needs to be upgraded to an allegation of abuse, staff is to follow the reporting and documentation practices for allegations of abuse incidents.
- SKHOV Wide Incident Review Committee Chairperson will forward any findings/recommendations to the Chief Executive Officer or designee within two weeks of each review of the incident.
- SKHOV Wide Incident Review Committee Chairperson will enter the meeting minutes pertaining to the incident into IRMA within three weeks of the review of the incident.

Death (Serious Notable Occurrence)

- A death that did not occur under the auspices of an agency shall be reported in accordance with part 625 regulations.
- A death is considered to have occurred under the auspices of an agency if:
    - they were living in a residential facility certified or operated by OPWDD, including family care (but excluding free standing respite facilities), at the time if death or if the death occurred up to 30 days after they were discharged from the residential facility (unless they were admitted to a different residential facility in the OPWDD system in the meantime).
    - the death occurred during a stay at an OPWDD certified or operated free standing respite facility or was cause by a reportable incident or notable occurrence, that occurred at the facility within 30 days of discovery.
    - they received non-residential services operated, certified, or funded by OPWDD, and
        - The death occurred while they were receiving services; or
        - The death was caused by a reportable incident or notable occurrence that occurred within 30 days of discovery of death.
- In accordance with New York State Law and guidance issued by the Justice Center, the death of any individual who had received services operated or certified by OPWDD, within thirty days preceding his or her death, shall be reported to the Justice Center. This reporting is required

regardless of whether the death did or did not occur under the auspices of an agency.

Specifics of the reporting requirement are as follows

- The initial report shall be submitted, by SKHOV's chief executive officer or designee, through a statewide, toll-free telephone number, 1-855-373-2124.
- The initial report shall be submitted immediately upon discovery and in no case more than twenty-four hours after discovery.
- Subsequent information shall be submitted to the Justice Center, via IRMA, in a manner and on forms specified by the Justice Center, within five working days of discovery of the death.
- The results of an autopsy, if performed and if available to SKHOV, shall be submitted to the Justice Center, in a manner specified by the Justice Center, within sixty working days of discovery of the death. (The Justice Center may extend the timeframe for good cause.)
- If more than one agency provided services to the individual, there shall be one responsible agency that is designated to report the death of the individual. SKHOV responsible for reporting in accordance with this paragraph shall be the provider of the services to the individual (or sponsoring agency) in the order stated:
- OPWDD certified or operated residential facility, including a family care home, but not a free-standing respite facility;
- OPWDD certified or operated free standing respite facility, if the death occurred during the individual's stay at the facility, or was caused by a reportable incident or notable occurrence defined in sections 624.3 and 624.4 of the regulation, that occurred during a stay at the facility within thirty days of discovery of the death;
- OPWDD certified or operated day program (if the individual received services from more than one certified day program, the responsible agency shall be SKHOV that provided the greater duration of service on a regular basis);
    (a) MSC or PCSS (OPWDD operated services only);
    (b) HCBS Waiver services (OPWDD operated services only);
    (c) Care at Home Waiver services (OPWDD operated services only);
    (d) Article 16 clinic services;
    (e) FSS or ISS (OPWDD operated services only);
    (f) Any other service operated by OPWDD.
- Notwithstanding any other requirement in this subparagraph, there may be circumstances in which the death of an individual who resided at a certified residential facility, or was staying at a certified free-standing respite facility, was caused by a reportable incident or notable occurrence that occurred under the auspices of an OPWDD certified or operated day program within thirty days of discovery of the death; under these circumstances the certified day program shall be responsible for reporting the death.
- This requirement does not apply to the death of an individual who received only OPWDD funded services (such as community habilitation or supported employment services provided by a voluntary-operated agency), rather than services that are operated or certified by OPWDD.
- All deaths that are reported to the Justice Center shall also be reported to OPWDD.
  A death that occurred under the auspices of an agency shall be reported as a serious notable occurrence in accordance with the regulation.
  A death that did not occur under the auspices of an agency (e.g., the death of a person who received certified day habilitation services, but died at his or her private home of causes not associated with the day services) shall be reported in accordance with Part 625 of the regulation.
- The death of any individual who had received services certified, operated, or funded by OPWDD, and the death occurred under the auspices of SKHOV, shall be classified as a serious notable

occurrence, and reported and managed as such, in accordance with the requirements of the regulation.

- A death is considered to have occurred under the auspices of an agency if:
- the individual was living in a residential facility operated or certified by OPWDD, including a family care home (but excluding free standing respite facilities), at the time of his or her death, or if the death occurred up to thirty days after the individual was discharged from the residential facility (unless the person was admitted to a different residential facility in the OPWDD system in the meantime);
- The individual's death occurred during a stay at an OPWDD certified or operated free standing respite facility or was caused by a reportable incident or notable occurrence, defined in sections 624.3 and 624.4 of the regulation, that occurred at the facility within thirty days of discovery of the death; or the individual had received non-residential services operated, certified, or funded by OPWDD, and the death occurred while the individual was receiving services; or
- The death was caused by a reportable incident or notable occurrence, defined in sections 624.3 and 624.4 of the regulation that occurred within thirty days of discovery of the death.

Procedure for Death: Serious Notable Occurrence

Reporting

- The staff person who observed or discovered the incident will immediately notify their supervisor.
- The supervisor will immediately ensure that notifications to SKHOV agency management are made up to the Chief Executive Officer or designee and the Quality Assurance Department.
- The Quality Assurance Department will immediately notify IMU of the incident**.**
- The Quality Assurance Department will immediately notify the Justice Center of the incident to their Death Reporting Line Number at 1-855-373-2124.
- The Quality Assurance Department will immediately notify the Justice Center if there is any reason to suspect abuse or neglect related to a death to the VPRC Hotline at 1-855-373-2122.
- The Quality Assurance Department will ensure that the police are immediately notified.
- The supervisor will ensure that all other appropriate notifications (parent, Care Manager, corresponding programs, Jonathan's Law) within 24 hours from the completion of the OPWDD 147 incident report or Education NYC/ASP incident report.
- For Willowbrook individuals, the program and the Quality Assurance Department will ensure that all required notifications are made.
- The supervisor will ensure that the nurse is immediately notified.

Immediate Corrective Action(s)

- It is the responsibility of the staff that observed or discovered the incident to take whatever measures appear to be prudent to ensure the protection of any other individuals from injury, harm, or abuse and prompt provision of treatment or care, prior to notifying a supervisor.
- Upon being notified of the incident, it will also be the responsibility of the Director of the program or designee where the incident occurred to take whatever measures appear to be prudent to ensure the protection of any other individual from injury, harm, or abuse and prompt provision of treatment or care.

Investigative Process

- The Quality Assurance Department will immediately begin investigating the incident.
- For injuries unknown origin, all persons having contact with the individual within at least 24 hours prior to the discovery of the injury, must be interviewed.
- The Report of Death will be documented by the Director of Clinical Services and the Nursing Supervisor.
- For individuals residing in an ICF, the Quality Assurance Department will complete and forward the investigation to the Chief Executive Officer or designee within five working days of the occurrence or discovery of the incident.

- The investigation must be complete within 30 days of the occurrence or discovery of the incident. However, if the investigation is not completed within 30 days, there must be written justification as to why it exceeded 30 days. This justification should be documented in a monthly investigative report.
- If the investigation is not complete within 30 days, the assigned investigator will be responsible to enter a monthly update into IRMA until the incident is closed.
- The assigned investigator will enter a brief review to the summary of evidence and whatever specific investigatory actions were taken since the last update that was entered into IRMA.
- If there have been no additions to the summary of evidence or investigatory actions taken since the last report, the assigned investigation must specify in IRMA why no progress was made.

Documentation

- The supervisor will document the OPWDD 147 incident report or Education NYC/ASP incident report, excluding notifications, within 24 hours of the occurrence or discovery of the incident.
- The supervisor will immediately forward the OPWDD 147 incident report or Education NYC/ASP incident report to the IRC Chairperson.
- The IRC Chairperson will enter the designated information from the OPWDD 147 incident report, specified by OPWDD, into the Incident Report and Management Application (IRMA) within 24 hours of the occurrence or discovery of the incident (see IRMA section below). However, if unable to enter the information into IRMA within 24 hours of the occurrence or discovery due to weekend or holiday, the information may be entered until no later than the close of the next business day (see IRMA section below). In this event, the OPWDD 147 incident report must be completed and submitted to the DDSO within 24 hours of the occurrence or discovery of the incident.
- The supervisor will document all notifications (parent, Care Manager, RN, corresponding programs) within 24 hours from the completion of the OPWDD 147 incident report or the Education NYC/ASP incident report.
- The supervisor will immediately forward the notifications to the IRC Chairperson. The IRC Chairperson will then enter this information into IRMA (see Incident Report Management Application section below).
- The IRC Chairperson will enter the information from the Report of Death into IRMA for IMU within three working days of the occurrence or discovery of the incident.
- The Report of Death will be documented by the Director of Clinical Services and the Nursing Supervisor.
- The assigned investigator will retrieve the Report of Death from the Director of Clinical Services and the Nursing Supervisor and will enter the information into IRMA within 72 hours of the occurrence or the discovery of the death.
- Upon the death of a person receiving services, who does not reside in an OPWDD facility, the non-residential facility must complete the Report of Death. The form is to be completed to the best of the non-residential program's ability, incorporating whatever facts are known to staff. It is not necessary for SKHOV to intrude on a family's period of mourning to gather anything more than basic information.
- The Quality Assurance Department will submit a written report to the coroner/medical examiner and law enforcement officials for suicides, homicides or unexpected or accidental deaths within three working days of the occurrence or discovery of the incident.
- For individuals who were residing in a SKHOV certified facility, the Chief Executive Director or designee will request a copy of the autopsy report/toxicological reports from the coroner/coroner's physician/medical examiner, in writing.
- The Quality Assurance Department will be responsible to submit the autopsy results, if received, to both the Justice Center and IMU within 60 days or as soon as the results are received.
- The Quality Assurance Department will submit subsequent information to the Justice Center within 5 working days of the discovery of the death via IRMA.
- For Willowbrook individuals, the IRC Chairperson will submit the completed OPWDD 147 incident report to the appropriate Willowbrook representatives.
- The IRC Chairperson will submit the completed OPWDD 147 incident report or Education NYC/ASP incident report, notifications, Report of Death and the investigation to SKHOV Wide Incident Review Committee within 30 days of the occurrence or discovery of the incident.

Follow-Up

- The OPWDD 147 incident report or Education NYC/ASP incident report, the investigation, Report of Death will be presented to SKHOV Wide Incident Review Committee for review within 30 days of the occurrence or discovery of the incident. If after 30 days, the incident is still under investigation, an investigative update will be presented. Additional investigative findings will be presented at each meeting until the committee closes the case.
- The case will remain open until all requested information has been submitted to SKHOV Wide Incident Review Committee chairperson, and the Committee's review of the matter is satisfied.
- Within 30 days of the occurrence or discovery of the incident, the Quality Assurance Department will enter the final investigation into IRMA. If the investigation is not completed within 30 days, the Quality Assurance Department will keep IMU informed in writing, through IRMA, of the progress of the investigation every 30 days until the investigation is completed.
- SKHOV Wide Incident Review Committee Chairperson will forward any findings/recommendations to the Chief Executive Officer or designee within two weeks of each review of the incident.
- SKHOV Wide Incident Review Committee Chairperson will enter the meeting minutes pertaining to the incident into IRMA within two weeks of the review of the incident.

PROCEDURES FOR SIGNIFICANT INCIDENTS

Reporting

- The staff person who observed or discovered the incident will immediately notify their immediate supervisor.
- For injuries, the supervisor will ensure that the nurse is immediately notified.
- The supervisor will immediately ensure that notifications are made to SKHOV agency management up to the Chief Executive Officer or designee and the Quality Assurance Department.
- For significant incidents occurring in OPWDD certified programs (i.e., residential, certified day habilitation, etc.), the staff person(s) who observed or discovered the incident will report the incident to the Justice Center via the VPCR hotline.
- For significant incidents occurring in OPWDD certified programs (i.e., residential, certified day habilitation, etc.), if an issue occurs with the staff being unable to make the notification, the immediate supervisor will also report the incident to the Justice Center via the VPCR hotline.
- During business hours, the Quality Assurance Department will directly call the IMU compliance officer to notify them of the incident.
- During off hours, the Quality Assurance Department will call the IMU hotline to notify them of the incident.
- The supervisor will ensure that all other appropriate notifications (parent, Care Manager, QIDP for ICF, corresponding programs, Jonathan's Law) are made within 24 hours of the completion of the OPWDD 147 incident report (Initial IRMA entry) or Education NYC/ASP incident report.
- For Willowbrook individuals, the program and the Quality Assurance Department will ensure that all required notifications are made.
- When an individual is a victim of a crime (e.g. sexual abuse, physical abuse), the Director of the program or designee will ensure that law enforcement have been notified of the incident immediately. If applicable, this notification may be done through the Justice Center.

Immediate Corrective Action(s)

- It is the responsibility of the staff that observed or discovered the incident to take whatever measures appear to be prudent to ensure the protection of the individual from further injury, harm, or abuse and prompt provision of treatment or care.
- The Director of the program or designee where the incident occurred is responsible to separate consumers from each other, when applicable (conduct between persons receiving services i.e. sexual abuse). Additionally, they will ensure appropriate follow up is implemented which could include, providing counseling, conducting a body check, training pertinent staff, etc.

Investigative process

- The Quality Assurance Department will immediately begin an investigation of the incident unless OPWDD or the Justice Center advises the chief executive officer that the incident or occurrence will be investigated by OPWDD or the Justice Center and specifically relieves SKHOV of the obligation to investigate.
- SKHOV will begin an investigation immediately even when it anticipates that the Justice Center or Central Office of OPWDD will assume the responsibility for the investigation. However, if SKHOV can reasonably anticipate that the Justice Center or the Central Office of OPWDD are likely to investigate the incident, the actions taken by SKHOV are restricted to:
    - Securing and/or documenting (e.g. photographing) the scene as appropriate;
    - Collecting and securing physical evidence;
    - Taking preliminary statements from witnesses and involved parties; and
    - Performing such other actions as specified by the Justice Center or OPWDD.
- For injuries unknown origin, all persons having contact with the individual within 24 hours prior to the discovery of the injury, must be interviewed.
- When an incident or occurrence is investigated or reviewed by OPWDD and OPWDD makes recommendations to SKHOV concerning any matter related to the incident or occurrence (except during survey activities), SKHOV will either:
    - Implement each recommendation in a timely fashion and submit documentation of the implementation to OPWDD; or
    - In the event that SKHOV does not implement a particular recommendation, submit written justification to OPWDD, within a month after the recommendation is made, and identify the alternative means that will be undertaken to address the issue, or explain why no action is needed.
- When the Justice Center makes findings concerning matters referred to its attention and the Justice Center issues a report and recommendations to SKHOV regarding such matters, SKHOV will make a written response, within ninety days of receipt of such report, of action taken regarding each of the recommendations in the report.
- In the event that law enforcement directs that SKHOV forgo any of the actions specified above, SKHOV must comply with such direction.
- For individuals residing in an ICF, the Quality Assurance department will complete and forward the investigation to the Chief Executive Officer or designee and within five working days of the occurrence or discovery of the incident.
- The investigation must be complete within 30 days of the occurrence or discovery of the incident. However, if the investigation is not completed within 30 days, there must be written justification as to why it exceeded 30 days. This justification should be documented in a monthly investigative report.
- If the investigation is not complete within 30 days, the assigned investigator will be responsible to enter a monthly update into IRMA until the incident is closed.
- The assigned investigator will enter a brief review to the summary of evidence and whatever specific investigatory actions were taken since the last update that was entered into IRMA.
- If there have been no additions to the summary of evidence or investigatory actions taken since the last report, the assigned investigation must specify in IRMA why no progress was made.

Documentation

- The supervisor will document the OPWDD 147 incident report or Education NYC/ASP incident report, including any notifications that were made within that timeframe, within 24 hours of the occurrence or discovery of the incident.
- The supervisor will immediately forward the OPWDD 147 incident report or Education NYC/ASP incident report, including any notifications that were made within that timeframe, to the IRC Chairperson.

- The IRC Chairperson will enter the designated information from the OPWDD 147 incident report, specified by OPWDD, into the Incident Report and Management Application (IRMA) within 24 hours of the occurrence or discovery of the incident (see IRMA section below). However, if unable to enter the information into IRMA within 24 hours of the occurrence or discovery due to weekend or holiday, the information may be entered until no later than the close of the next business day (see IRMA section below). In this event, the OPWDD 147 incident report must be completed and submitted to IMU within 24 hours of the occurrence or discovery of the incident.
- The IRC Chairperson will forward the OPWDD 147 incident report via fax to MHLS within three working days of the occurrence or discovery of the incident for individuals residing in a certified facility.
- The supervisor will document all other appropriate notifications (parent, Care Manager, QIDP for ICF, RN, corresponding programs) within 24 hours of the completion of the OPWDD 147 incident report or the Education NYC/ASP incident report.
- The supervisor will immediately forward the completed notifications to the IRC Chairperson. The IRC Chairperson will then enter this information into IRMA. See IRMA section below.
- For Willowbrook individuals, the IRC Chairperson will submit the completed OPWDD 147 incident report to the appropriate Willowbrook representatives.
- The IRC Chairperson will submit the completed OPWDD 147 incident report or Education NYC/ASP incident report, notifications and investigation to SKHOV Wide Incident Review Committee within 30 days of the occurrence or discovery of the incident.

Follow-Up

- The OPWDD 147 incident report or Education NYC/ASP incident report, notifications and the investigation will be presented to SKHOV Wide Incident Review Committee for review within 30 days of the occurrence or discovery of the incident. An investigation shall be considered complete upon completion of the investigative report. If after 30 days, the incident is still under investigation, an investigative update will be presented. Additional investigative findings will be presented at each meeting until the committee closes the case. An incident or occurrence shall be considered closed:
    1. When the IRC has ascertained that no further investigation is necessary; or
    2. In the event that an investigation was conducted by the Central Office of OPWDD, when the Central Office of OPWDD has ascertained that no further investigation is necessary; or
    3. In the event that an investigation was conducted by the Justice Center, when the Justice Center has ascertained that no further investigation is necessary.
- The case will remain open until all requested information has been submitted to SKHOV Wide Incident Review Committee chairperson, and the Committee's review of the matter is satisfied.
- Within 30 days of the occurrence or discovery of the incident, the Quality Assurance Department will enter the final investigation into IRMA.
- If the investigation is not completed within 30 days, the Quality Assurance Department will keep IMU informed in writing, through IRMA, of the progress of the investigation every 30 days until the investigation is completed.
- In the event that the Central Office of OPWDD or the Justice Center conducts the investigation the Central Office of OPWDD is responsible to enter the investigative report into IRMA.
- SKHOV Wide Incident Review Committee Chairperson will forward any findings/recommendations to the Chief Executive Officer or designee within two weeks of each review of the incident.
- SKHOV Wide Incident Review Committee Chairperson will enter the meeting minutes pertaining to the incident into IRMA within three weeks of the review of the incident.

Policy for Missing Person

- The missing person procedures must be followed for the unexpected absence of an individual receiving services that based on the person's history and current condition exposes him or her to risk of injury.

Procedure for Missing Person

When an individual's whereabouts become unknown, follow the steps outlined below:

- **Day Habilitation**: Search the immediate area for one minute- if the individual is not found within one minute, immediately contact the Senior Director of Day Services. If unable to reach the Senior Director of Day Services, staff will attempt contact an immediate supervisor until they are able to make contact with one. The Senior Director of Day Services or other supervisor contacted will ensure that the police are notified.
- **Residential**: Search the immediate area for one minute- if the individual is not found within one minute, contact the supervisor on shift. If unable to reach the supervisor on shift, staff will follow the chain of command until they are able to make contact with a supervisor. The supervisor on shift or other supervisor contacted will ensure that the police are notified.
- **Afterschool Programs/Saturday Recreation:** Search the immediate area for one minute- if the individual is not found within one minute, contact the supervisor on shift. If unable to reach a supervisor on shift, staff will follow the chain of command until they are able to make contact with a supervisor. The supervisor on shift or other supervisor contacted will ensure that the police are notified.
- **Day School/Preschool:** Staff will immediately notify an on-site supervisor, the program will conduct a five minute search, and if the individual is not found with five minutes, a supervisor will notify the police.
- **Family Services**: Search the immediate area for one minute- if the individual is not found within one minute, the staff will first notify the police and then their supervisor. If unable to reach their supervisor, staff will follow the chain of command until they are able to make contact with a supervisor.
- The supervisor will notify the Quality Assurance Department.
- For individuals receiving OPWDD services, the Quality Assurance Department will notify IMU of the missing individual.
- When the missing individual is found, a full body check will be conducted. Contingent upon the findings of the body check, the individual's functioning level, length of time the individual was missing, and the individual's capacity to participate with the investigative process, it may be necessary for an individual to go to the emergency room.
- A nurse will be contacted to assess the situation. If a nurse is unable to physically examine the individual, the President/COO or designee will make the final decision to determine whether or not an individual requires medical attention.

Policy for Unauthorized Absence

- The unauthorized absence procedures must be followed for the unexpected or unauthorized absence of an individual receiving services based on reasoned judgments, taking into consideration the person's habits, deficits, capabilities, health problems, etc., determine when formal search procedures need to be implemented. It is required that formal search procedures must be initiated immediately upon discovery of an absence involving a person whose absence constitutes a recognized potential danger to the wellbeing of the person or others.

Procedure for Unauthorized Absence

- In all programs, when an individual's whereabouts become unknown, the staff who discovered that the individual is missing must immediately notify a supervisor.
- Upon being notified that the individual is missing, the supervisor will be responsible to determine when formal search procedures should be implemented, including notifying the police and distribution to the police

and community members of a Missing Person Flyer.

- The supervisor will notify the Quality Assurance Department.
- For individuals receiving OPWDD services, the Quality Assurance Department will notify IMU of the missing individual.
- When the missing individual is found, a full body check will be conducted. Contingent upon the findings of the body check, the individual's functioning level, length of time the individual was missing, and the individual's capacity to participate with the investigative process, it may be necessary for an individual to go to the emergency room.
- A nurse will be contacted to assess the situation. If a nurse is unable to physically examine the individual, the President/COO or designee will make the final decision to determine whether or not an individual requires medical attention.

ALLEGATIONS OF ABUSE

Reporting

- The staff person who observed or discovered the incident will immediately notify their immediate supervisor.
- For injuries, the supervisor will ensure that the nurse is immediately notified.
- The supervisor will immediately ensure that notifications are made to SKHOV agency management up to the Chief Executive Officer or designee and the Quality Assurance Department.
- For allegation of abuse incidents occurring in OPWDD certified programs (i.e., residential, certified day habilitation, etc.), the staff person(s) who observed or discovered the incident will report the incident to the Justice Center via the VPCR hotline.
- For allegation of abuse incidents occurring in OPWDD certified programs (i.e., residential, certified day habilitation, etc.), if an issue occurs with the staff being unable to make the notification, the immediate supervisor will also report the incident to the Justice Center via the VPCR hotline.
- The Quality Assurance Department will immediately notify IMU of the incident. (either direct IMU line or IMU hotline, depending on whether the notification is during business hours or not)
- The supervisor will ensure that all other appropriate notifications (parent, Care Manager, QIDP for ICF, corresponding programs, Jonathan's Law) are made within 24 hours of the completion of the OPWDD 147 incident report (Initial IRMA entry) or Education NYC/ASP incident report.
- For Willowbrook individuals, the program and the Quality Assurance Department will ensure that all required notifications are made.

Reporting to law enforcement

- An appropriate law enforcement official must be contacted immediately in the event that an emergency response by law enforcement is needed.
- Agencies shall report to an appropriate law enforcement official anytime a crime may have been committed against an individual by a custodian. This is in addition to reporting to the Justice Center when the event or situation is a reportable incident (if the services are certified or operated by OPWDD).
- The report to the appropriate law enforcement official shall be made as soon as practicable, but in no event later than 24 hours after occurrence or discovery.
- Information about the report to the appropriate law enforcement official shall be entered into IRMA within 24 hours of the report being made.
- For allegations of psychological abuse pertaining to individuals at certified facilities, the Quality Assurance Department will notify the Director of Nursing and the Clinical Director that a nursing assessment must be completed and an initial clinical assessment must commence. Note: Once the assigned investigator determines whether or not the alleged abusive actions occurred or not, he/she will notify the Clinical Director,

to inform he/she if a full clinical assessment is required (See 624 Handbook-Appendix 1).

Immediate Corrective Action(s)

- It is the responsibility of the staff that observed or discovered the alleged abuse to take whatever measures appear to be prudent to ensure the protection of the individual from further injury, harm, or abuse and prompt provision of treatment or care.
- The Director of the program or designee where the alleged abuse occurred is responsible for removal, reassignment, relocation, suspension or increasing the degree of supervision of the employee who allegedly abused the individual, when applicable, pending on the results of the investigation. Additionally, the Director of the program is responsible to ensure appropriate follow up is implemented which could include, include providing counseling, conducting a body check, training staff pertinent to the prevention and remediation of the abuse. Furthermore, the Director of the program or designee is responsible to separate consumers from each other, when applicable (i.e. sexual abuse).

Investigative process

- The Quality Assurance Department will immediately begin an investigation of the incident unless OPWDD or the Justice Center advises the chief executive officer that the incident or occurrence will be investigated by OPWDD or the Justice Center and specifically relieves SKHOV of the obligation to investigate.
- SKHOV shall commence an investigation immediately even when it anticipates that the Justice Center or Central Office of OPWDD will assume the responsibility for the investigation. However, if SKHOV can reasonably anticipate that the Justice Center or the Central Office of OPWDD are likely to investigate the incident, the actions taken by SKHOV are restricted to:
    - Securing and/or documenting (e.g. photographing) the scene as appropriate;
    - Collecting and securing physical evidence;
    - Taking preliminary statements from witnesses and involved parties; and
    - Performing such other actions as specified by the Justice Center or OPWDD.
- For injuries unknown origin, all persons having contact with the individual within 24 hours prior to the discovery of the injury, must be interviewed.
- For allegations of psychological abuse, a clinical assessment, including a nursing assessment, must be completed to determine if the alleged conduct caused a substantial diminution of the emotional, social, or behavioral development or condition of the individual.
- When an incident or occurrence is investigated or reviewed by OPWDD and OPWDD makes recommendations to SKHOV concerning any matter related to the incident or occurrence (except during survey activities), SKHOV shall either:
    - Implement each recommendation in a timely fashion and submit documentation of the implementation to OPWDD; or
    - In the event that SKHOV does not implement a particular recommendation, submit written justification to OPWDD, within a month after the recommendation is made, and identify the alternative means that will be undertaken to address the issue, or explain why no action is needed.
- When the Justice Center makes findings concerning matters referred to its attention and the Justice Center issues a report and recommendations to SKHOV regarding such matters, SKHOV shall make a written response, within ninety days of receipt of such report, of action taken regarding each of the recommendations in the report.
- In the event that law enforcement directs that SKHOV forgo any of the actions specified above, SKHOV shall comply with such direction.
- For individuals residing in an ICF, the Quality Assurance department will complete and forward the investigation to the Chief Executive Officer or designee and within five working days of the occurrence or

discovery of the incident.

- The investigation must be completed within 30 days after completion of the OPWDD 147. However, if the investigation is not completed within 30 days, there must be written justification as to why it exceeded 30 days. This justification should be documented in a monthly investigative report.
- **For certified facilities, the following actions must be taken:**
    - The program must complete the OPWDD 163 Personal Representative Form and Initial Effective Communication Form within the required timeframes and forward them to the assigned investigator. Note: in order to not delay the investigation, if the program cannot reach the parent/guardian/advocate within the required timeframes, then the interviews may be conducted prior to the completion of these forms.
    - If the personal representative requests to be present for the interview, they may be present prior to and after the interview, but in order to protect the confidentiality of other SKHOV individuals and SKHOV staff, they may not be present during the interview.
    - The assigned investigator will complete a Statewide Central Register Check Form for the target of the investigation and submit it to subjectsearchs@justicecenter.ny.gov.
    - The assigned investigator will complete an Investigations Notice to Suspect or Subject of Abuse or Neglect Form and mail it to the target of the investigation.
    - If the investigation identifies additional targets, the assigned investigator will email the additional name to incidentreview@justicecenter.ny.gov.

Documentation

The supervisor will document the OPWDD 147 incident report or Education NYC/ASP incident report, including any notifications that were already made, within 24 hours of the occurrence or discovery of the incident.

The supervisor will immediately forward the OPWDD 147 incident report or Education NYC/ASP incident report, including any notifications that were made within that timeframe, to the IRC Chairperson.

The IRC Chairperson will enter the designated information from the OPWDD 147 incident report, specified by OPWDD, into the Incident Report and Management Application (IRMA) within 24 hours of the occurrence or discovery of the incident (see IRMA section below). However, if unable to enter the information into IRMA within 24 hours of the occurrence or discovery due to weekend or holiday, the information may be entered until no later than the close of the next business day (see IRMA section below).

The IRC Chairperson will forward the OPWDD 147 incident report via fax to MHLS within three working days of the occurrence or discovery of the incident for individuals residing in a certified facility.

The supervisor will document all other appropriate notifications (parent, Care Manager, QIDP for ICF, RN, corresponding programs) within 24 hours of the completion of the OPWDD 147 incident report or the Education NYC/ASP incident report.

The supervisor will immediately forward the completed notifications to the IRC Chairperson. The IRC Chairperson will then enter this information into IRMA. See IRMA section below.

For Willowbrook individuals, the IRC Chairperson will submit the completed OPWDD 147 incident report to the appropriate Willowbrook representatives.

The IRC Chairperson will submit the completed OPWDD 147 incident report or Education NYC/ASP incident report, notifications and investigation to SKHOV Wide Incident Review Committee within 30 days of the occurrence or discovery of the incident.

Follow-Up

- The OPWDD 147 incident report or Education NYC/ASP incident report, notifications and the investigation will be presented to SKHOV Wide Incident Review Committee for review within 30 days of the occurrence or discovery of the incident. An investigation shall be considered complete upon completion of the investigative report. If after 30 days, the incident is still under investigation, an investigative update will be presented. Additional investigative findings will be presented at each meeting until the committee closes the case. An incident or occurrence shall be considered closed:

(1) When the IRC has ascertained that no further investigation is necessary; or
(2) In the event that an investigation was conducted by the Central Office of OPWDD, when the Central Office of OPWDD has ascertained that no further investigation is necessary; or
(3) In the event that an investigation was conducted by the Justice Center, when the Justice Center has ascertained that no further investigation is necessary.

- The case will remain open until all requested information has been submitted to SKHOV Wide Incident Review Committee chairperson, and the Committee's review of the matter is satisfied.
- Within 30 days of the occurrence or discovery of the incident, the Quality Assurance Department will enter the final investigation into IRMA and for allegations of abuse occurring with individuals residing in certified facilities, send out the final investigative report to MHLS via fax and for Willowbrook individuals, send out the final investigative report to the appropriate Willowbrook representative. If the investigation is not completed within 30 days, the Quality Assurance Department will keep IMU informed in writing, through IRMA, of the progress of the investigation every 30 days until the investigation is completed. MHLS will only receive the final investigative report; monthly reports to MHLS are not required. (Note: In the event that the Central Office of OPWDD or the Justice Center conducts an investigation of a "reportable" incident or notable occurrence, the Central Office of OPWDD will enter the investigative report into IRMA.)
- SKHOV Wide Incident Review Committee Chairperson will forward any findings/recommendations to the Chief Executive Officer or designee within two weeks of each review of the incident.
- SKHOV Wide Incident Review Committee Chairperson will enter the meeting minutes pertaining to the incident into IRMA within three weeks of the review of the incident.
- For Willowbrook individuals, within 24 hours of entering the Incident Review Committee meeting minutes into IRMA, the IRC Chairperson will email the meeting minutes for the Willowbrook individual to the appropriate Willowbrook representative.

Final reports to the Justice Center

- Agencies shall submit a final report to OPWDD for all reportable incidents that were accepted by the VPCR.
- Final reports must be submitted in the manner, form and format specified by the Justice Center.
- If an agency conducts the investigation of an allegation of abuse or neglect that was reported to the Justice Center, SKHOV shall submit the entirety of the investigation records, including the final report, to OPWDD upon completion of the investigation.
- SKHOV may take additional time to submit its final report provided, however, that the reasons for any delay must be for good cause and must be documented. The report must be submitted as soon thereafter as practicably possible.
- In the event that the Justice Center or OPWDD conducts the investigation in lieu of SKHOV, SKHOV is not required to submit the final report to the Justice Center. In the event that OPWDD conducts the investigation, OPWDD will submit the final report to the Justice Center. However, agencies shall provide information as requested by the Justice Center or OPWDD as may be necessary for the completion of the final report.

Plans for prevention and remediation for substantiated allegations of abuse or neglect

- Within 10 days of IRC review of the completed investigation, if the allegation of abuse or neglect has been substantiated, SKHOV shall develop a plan of prevention and remediation to be taken to assure the continued health, safety, and welfare of individuals receiving services and to provide for the prevention of future acts of reportable incidents.
- The plan shall include written endorsement by the CEO or designee.
- The plan shall identify projected implementation dates and specify by title agency staff who are

responsible for monitoring the implementation of each remedial action identified and for assessing the efficacy of the remedial action.

- Such plan shall be entered into IRMA by the close of the fifth working day after the development of the plan.
- OPWDD will inform the Justice Center about plans developed pursuant to this section.

Full Investigative file for allegations of abuse:

- For allegations of abuse that occur at a certified facility, within 50 days from the when the incident was entered into IRMA, the assigned investigator must submit the full investigative file into the Web Submission of Investigation Report (WSIR).
- For allegations of abuse that occur at a non-certified facility, within 50 days from the when the incident was entered into IRMA, the assigned investigator must submit the full investigative file into IRMA.

Administrative Action Reporting Mechanism (AARM)

- For category 1-3 substantiated abuse, upon receiving email notification from the Justice Center, the assigned investigator must submit the administrative actions that were taken against the target, via the AARM web application @ https://vpcr.justicecenter.ny.gov/SEL/.

Corrective Action Plan (CAP)

- For incidents occurring in certified facilities, within 65 days of the date of the Justice Center Letter of Determination (LOD), the assigned investigator must input/upload all corrective actions taken for the incident and supporting documentation into IRMA.
- For incidents occurring in non-certified facilities, the assigned investigator must input all corrective actions taken for the incident into IRMA.

POLICY ON PROVIDING INFORMATION PERTAINING TO INCIDENTS TO Care Managers/Qualified Intellectual Disabilities Professional/Willowbrook Care Managers

SKHOV will provide the care manager or the QIDP with subsequent information which may be needed to update an individual's plan of services and to monitor protective, corrective, and other actions taken following a significant incident, allegation of abuse and minor/serious notable occurrence.

PROCEDURE ON PROVIDING INFORMATION PERTAINING TO INCIDENTS TO Care Managers/Qualified Intellectual Disabilities Professional/Willowbrook Care Managers

The assigned investigator must provide the care manager or qualified intellectual disabilities professional (QIDP) for ICFs only with written information identifying investigative conclusions including the findings of an allegation of abuse or neglect and recommendations pertaining to the individual's care, protection, and treatment within 10 days following completion of the investigation.

If the IRC review results in additional findings, conclusions, or recommendations regarding the individual's care, protection, and/or treatment, the assigned investigator must provide this information to the care manager or the QIDP, in writing, within 3 weeks following committee review.

The care manager or QIDP may request additional information concerning the incident or occurrence in order to monitor protective, corrective, and/or other actions taken. In the event that SKHOV receives a request for this information from a care manager or the QIDP, SKHOV will provide information that it deems appropriate.

When providing this information, SKHOV must exclude information that directly or indirectly identifies agency employees, consultants, contractors, volunteers, and other individuals receiving services. If SKHOV determines that it would be inappropriate to disclose specific information requested, SKHOV must advise the care manager or the QIDP of this determination and its justification, in writing, within 10 days following the request. If SKHOV does not have specific information requested by the care manager or QIDP, e.g. if the Justice Center conducted the investigation and it has not provided that information to SKHOV, SKHOV must advise the care manager or the QIDP that it

does not have the requested information. If the information may be available from the Justice Center SKHOV will also advise the care manager.

If the care manager or QIDP is identified as the subject of a report of an allegation of abuse or neglect or as a witness to a reportable incident or occurrence, SKHOV will not provide information to that party. In such a case, notifications and written information identified will be provided to the care manager's or QIDP's supervisor or the administrator of SKHOV providing care management in lieu of the care manager or QIDP.

When providing any the information to the care manager or the QIDP, the assigned investigator/SKHOV must exclude information that directly or indirectly identifies agency employees, consultants, contractors, volunteers, or other individuals receiving services.

INCIDENT CLOSURE

For all significant incidents (whether applicable to the Justice Center or not) and for allegations of abuse that are not applicable to the Justice Center

- If SKHOV conducts the investigation, closure is when the IRC ascertained that no further investigation is necessary.
- If OPWDD conducts the investigation, closure is when OPWDD notifies SKHOV of the results of the investigation.

For allegations of abuse applicable to the Justice Center

- If SKHOV conducts the investigation, closure is when the Justice Center accepts the results of the investigation.
- If OPWDD conducts the investigation, closure is when the Justice Center accepts the results of the investigation.
- If Justice Center conducts the investigation, closure is when the Justice Center provides SKHOV with the results of the investigation.

ELDER JUSTICE ACT- (ICF Requirement)

(1) IN GENERAL- Each ICF staff shall report any reasonable suspicion of a crime against any individual who is a resident of, or is receiving care from the ICF, to the Office for People With Developmental Disabilities (OPWDD) at 1-866-946-9733 and local law enforcement at 718-712-7733.
(2) TIMING- If the events that cause the suspicion-

A. Result in serious bodily injury, the staff shall report the suspicion immediately, but not later than 2 hours after forming the suspicion.
B. Do not result in serious bodily injury, the staff shall report the suspicion not later than 24 hours after forming the suspicion.

Reports of the reasonable suspicion of a crime against a resident of this facility must be made in accordance with SKHOV's incident management policy. This policy mandates that any suspected abuse against any individuals receiving services from SKHOV, including possible crimes, must be reported to a supervisor immediately.

SKHOV may not retaliate against any employee who lawfully reports the reasonable suspicion of a crime against a resident as provided in Section 1150B of the Social Security Act.

SKHOV may not discharge, demote, suspend, threaten, harass, or deny a promotion or other employment-related benefit to an employee, or in any other manner discriminate against an employee, in terms and conditions of employment because of lawful acts done by the employee for making a report, causing a report to be made, or for taking steps in furtherance of making a report pursuant to the Act.

SKHOV may not file a complaint or report against a nurse or other employee with the appropriate state professional disciplinary agency because of lawful acts done by the employee for making a report, causing a report to be made, or for taking steps in furtherance of making a report pursuant to the Act.

An employee may file a complaint with the Office for People With Developmental Disabilities against SKHOV if it retaliates against an employee who has lawfully reported the suspicion of a crime against a resident. To file a complaint for programs surveyed by the Office for People With Developmental Disabilities, you may call the OPWDD information line at 1-866-946-9733.

Annual Notification to ICF Staff:

- Annually, staff must be notified of their reporting obligations described above, related to section 1150B(b) of the Social Security Act.

Requirement to Post Notice:

- The facility must conspicuously post a notice (see next page for notice) specifying the rights of employees, specified above, under section 1150B(d). Such notice shall include a statement that an employee may file a complaint with the State Survey Agency against the facility that violates the provisions of section 1150B(d) and information with respect to the manner of filing such a complaint.
- The sign may be posted in the same area that the facility posts other required employee signs, such as labor management posters.
- Size and type requirements for the sign should be no less than the minimum required for the other required employment-related signs.

ELDER JUSTICE ACT
UNDER 6703 (B) (3) OF THE PATIENT PROTECTION AND AFFORDABLE CARE ACT OF 2010

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Section 1150 B of the Social Security Act established by section 6703(b)(3) of the Patient Protection and Affordable Act of 2010 requires reporting of any reasonable suspicion of crimes committed against any resident living in a residential facility. The Centers for Medicare and Medicaid services issued a survey and certification memo on June 17, 2011 and revised on January 20, 2012 entitled "Reporting Reasonable Suspicion of a Crime in a Long Term Care Facility (LTC): section 1150B of the Social Security Act" (ICFs are a type of these long term care facilities).

Each employee is individually responsible to report the reasonable suspicion of a crime against a resident. Employees who fail to report are subject to a civil penalty and exclusion from participating in any Federal health care program.

Reports of the reasonable suspicion of a crime against a resident of this facility must be made in accordance with SKHOV's incident management policy. This policy mandates that any suspected abuse against any individuals receiving services from SKHOV, including possible crimes, must be reported to a supervisor immediately.

SKHOV may not retaliate against any employee who lawfully reports the reasonable suspicion of a crime against a resident as provided in Section 1150B of the Social Security Act.

SKHOV may not discharge, demote, suspend, threaten, harass, or deny a promotion or other employment-related benefit to an employee, or in any other manner discriminate against an employee, in terms and conditions of employment because of lawful acts done by the employee for making a report, causing a report to be made, or for taking steps in furtherance of making a report pursuant to the Act.

SKHOV may not file a complaint or report against a nurse or other employee with the appropriate state professional disciplinary agency because of lawful acts done by the employee for making a report, causing a report to be made, or for taking steps in furtherance of making a report pursuant to the Act.

An employee may file a complaint with the Office for People With Developmental Disabilities against SKHOV if it retaliates against an employee who has lawfully reported the suspicion of a crime against a resident. To file a complaint for programs surveyed by the Office for People With Developmental Disabilities, you may call the OPWDD information line at 1-866-946-9733.

JONATHAN'S LAW

POLICY
Jonathan's Law, effective May 7, 2007, requires a more extensive notification process of certain incidents and all allegations of abuse and provides certain parties access to records/documents concerning allegations of abuse. This policy applies to all facilities and services operated, certified, authorized, or funded through contract by OPWDD. The following types of events/situations are subject to the Jonathan's Law requirements:

- Allegations of Abuse
- Significant Incidents
- Serious Notable Occurrences
- Minor Notable Occurrences

Notification and disclosure requirements pertaining to Jonathan's Law do not apply to events or situations which are not under the auspices of SKHOV, such as an allegation of abuse at a private home where the parent/home health aid is the target, incident at a public school, etc. These incidents still follow "normal" OPWDD incident management procedures. However, if an incident involving SKHOV staff takes place in the private home, Jonathan's Law will apply.

This law does not apply if the person who would otherwise be notified is the alleged abuser or if the Parent/Guardian/Spouse/Adult Child/Adult Sibling/Advocate/ Correspondent objects to notification to himself or herself.

PROCEDURE
Upon the discovery of allegations of abuse, significant incidents, serious notable occurrences or minor notable occurrences, a supervisor (any position from a Shift Supervisor up to the Chief Executive Officer) must notify the Parent/Guardian/Spouse/Adult Child/Adult Sibling/Advocate/ Correspondent (Qualified Person) as soon as possible, but no later than 24 hours after the completion of the OPWDD 147 incident report.

Notification to the Parent/Guardian/Qualified Person
The notification must include the following:

- A brief summary of the facts of the incident that are known at the time of the notification. Special care should be taken not to include speculation or opinion.
- Initial actions taken to address the situation and to protect the health and safety of the individual, including:
- Medical or dental treatment provided
- Administrative actions taken (increased supervision, target placed on leave)
- Environmental modifications made (e.g. repairs to a faulty step)
- Counseling provided (to staff or person receiving services)
- The names of other individuals receiving services or staff should not be included in the summary.

If the supervisor cannot reach the Parent/Guardian/Qualified Person, the supervisor must document on the Jonathan's Law forms the name of the person a message was left with or if a message was left on voicemail. If unable to leave a message, the supervisor must indicate that he/she were unable to leave a message. Each attempt to contact the Parent/Guardian/Qualified Person must be documented on the Jonathan's Law forms until contact is made. If the

supervisor is unable to contact the Parent/Guardian/Qualified Person within 24 hours after the completion of the OPWDD 147 incident report, a letter explaining that attempts were made to notify them of the incident via phone, and the 148 report, must be sent out to them via standard mail no later than 7 days from the occurrence or discovery of the incident.

Offer of a Meeting

When contact is made with the Parent/ Guardian/ Qualified Person they must be offered the opportunity to attend a meeting with the Chief Executive Officer or designee to further discuss the incident. The supervisor must document on the Jonathan's Law forms the date the meeting was either accepted or declined and whether the offer of a meeting was made verbally or in writing. If the offer of a meeting was made in writing, a copy of the offer must be filed with the Jonathan's Law forms.

If the Parent/Guardian/Qualified Person agrees to a meeting, according to SKHOV policy, the meeting must be held within two weeks from the date that they accepted the offer, unless the Parent/Guardian/Qualified Person requests that the meeting be held at a later date. The date of the scheduled meeting must be documented on the Jonathan's Law forms. The supervisor will arrange the meeting and select attendance depending on the nature of the incident. The supervisor will ensure that a sign-in sheet is utilized and meeting minutes are taken. The sign-in sheet must then be filed with the Jonathan's Law forms.

Report on Actions Taken- 148 Report

The supervisor must provide the "Report on Actions Taken" 148 report to the Parent/ Guardian/ Qualified Person within 10 days of the completion of the OPWDD 147 incident report. In order to meet this requirement, the supervisor must automatically mail the "Report on Actions Taken" 148 report to the Parent/ Guardian/ Qualified Person within seven days of the completion of the OPWDD 147 incident report via standard mail. The supervisor must ensure that any information noted on the 148 report tending to identify others involved in the incident is omitted from the form. A copy of the stamped envelope and a copy of the 148 report must be filed with the Jonathan's Law forms. A copy of the 148 report must be forwarded to SKHOV Wide Incident Review Committee. The date that the 148 report was mailed out must be indicated on the Jonathan's law forms.

Request for a Copy of the OPWDD 147 Incident Report

If the Parent/ Guardian/ Qualified Person requests a copy of the OPWDD 147 incident report (this is not offered) in writing, the supervisor must provide a copy to the Parent/ Guardian/ Qualified Person within 10 days of the request. The OPWDD 147 incident report can either be a copy of the report that was completed by SKHOV or the printed report from IRMA. In order to meet this requirement, the supervisor will send out a copy of the OPWDD 147 incident report to the Parent/ Guardian/ Qualified Person via standard mail within seven days of the request. The supervisor must attach a cover letter explaining that all information in the OPWDD 147 incident report is preliminary and has not been substantiated. The supervisor must also document the date of the request, whether the request was made verbally or in writing and the date the copy of the OPWDD 147 incident report was mailed out. If the request was made in writing, a copy of the request must be filed with the Jonathan's Law forms. Furthermore, the supervisor must ensure that any information noted on the OPWDD 147 incident report tending to identify others involved in the incident is redacted from the report. Note: The OPWDD 147 incident report to be given to the Parent/ Guardian/ Qualified Person should not include the notifications page for the incident. A copy of the stamped envelope and a copy of the redacted OPWDD 147 incident report must be filed with the Jonathan's Law forms.

When SKHOV denies a request for the OPWDD 147 incident report, SKHOV will inform the requestor in writing of the opportunity to appeal such denial to the OPWDD Incident Records Appeals Officer. SKHOV shall inform the requestor of the opportunity to send his or her written appeal to the OPWDD Incident Records Appeals Officer, Office of Counsel, 44 Holland Avenue, Albany, NY, 12229.

Jonathan's Law Forms

- The supervisor must forward the completed Jonathan's Law forms to SKHOV Wide Incident Review Committee within 30 days of the occurrence or discovery of the incident.

RELEASE OF RECORDS AND DOCUMENTS PERTAINING TO SIGNIFICANT INCIDENTS & ALLEGATIONS OF ABUSE

POLICY

- If requested, SKHOV is required to release records and documents pertaining to significant incidents & allegations of abuse to the Parent/Guardian/Qualified Person which occurred or were discovered on or after May 5, 2007.
- SKHOV is also required to release records and documents pertaining to significant incidents & allegations of abuse to the Parent/Guardian/Qualified Person covering the period of January 1, 2003 to May 5, 2007. However, Parents/Guardians/Qualified Persons have until December 31, 2015 to make these requests.
- Each facility has a binder containing Jonathan's Law documentation. For confidentiality purposes, this binder must be kept in a secured area and should only be accessible to authorized personnel.
- Any position from a Shift Supervisor up to the Chief Executive Officer is authorized to receive requests for these records and documents and is also authorized to release these documents to the appropriate parties.
- Requests for records and documents must be made by an eligible requestor in writing
- The written request should specify what records and documents are being requested. Requests may be for all records and documents subject to release or may be limited. Agencies may wish to discuss the types of records and documents that are available with a requestor to help the requestor identify the documents that may be of interest and to assist the requestor in framing the request. The request can be limited to specific documents or types of documents of interest to the requestor (i.e. investigative report, witness statements, supporting documents, photographs, medical information, etc.).
- Eligible requestors for records and documents pertaining to a significant incident or allegation/ investigation of abuse are:
- A person receiving services who is the subject of the alleged abuse; and
- Any guardian, parent, spouse or adult child of the person receiving services who is the subject of the alleged abuse.
- If the person receiving services is the target of a report (there may be an allegation that he or she abused another person receiving services), qualified persons associated with the person who is targeted are not eligible to receive copies of the records and documents pertaining to that investigation.
- If more than one eligible person requests the investigation records and documents, the documents must be provided to all eligible requestors.
- In the event that an otherwise eligible requestor is an alleged abuser, such requestor is not eligible to receive any records or documents pertaining to the specific allegation or investigation of the event or situation in which he or she was the alleged targeted alleged abuser, regardless of the conclusion.
- Employee personal files or disciplinary procedures are not to be considered "pertaining to allegations and investigations into abuse."
- If the release of records and documents might cause harm or be detrimental to the person receiving services or others, an attorney should be consulted before the release about whether the request could be denied or whether specific records could be withheld. For example, information contained in requested records or documentation may cause the requestor to seek retaliation against the person receiving services.
- A cover letter must be provided along with the records. The cover letter must include specific language about dissemination of records: Pursuant to section 33.25 of the Mental Hygiene Law, the enclosed documents shall not be further disseminated, EXCEPT that you may share the report with: (1) A Health Care Provider; (2) A Behavioral Health Care Provider; (3) Law Enforcement, if you believe a crime may have been committed; or (4) Your Attorney.

PROCEDURE

- The supervisor must document on the Jonathan's Law forms when the request was made for all records and documents pertaining to the significant incidents or allegation of abuse by the Parent/Guardian/ Qualified Person. A copy of the request must be filed with the Jonathan's Law forms.
- The supervisor will immediately notify the Director of Quality Assurance or designee of the request via e-mail.
- The supervisor will send the records and documents to the Parent/Guardian/Qualified Person via standard mail within 21 days of the closure of the case or within 21 days of the request if the case has already been closed. In

order to meet this requirement, the Director of Quality Assurance or designee will send out the records and documents to the Parent/Guardian/Qualified Person within 18 days of the closure of the case or within 18 days of the request if the case has already been closed, via standard mail.

For all significant incidents (whether applicable to the Justice Center or not) and for allegations of abuse that are not applicable to the Justice Center:

- If SKHOV conducts the investigation, closure is when the IRC ascertained that no further investigation is necessary
- If OPWDD conducts the investigation, closure is when OPWDD notifies SKHOV of the results of the investigation

For allegations of abuse applicable to the Justice Center:

- If SKHOV conducts the investigation, closure is when the Justice Center accepts the results of the investigation
- If OPWDD conducts the investigation, closure is when the Justice Center accepts the results of the investigation
- If Justice Center conducts the investigation, closure is when the Justice Center provides SKHOV with the results of the investigation
- A letter must accompany the records/documents sent to the Parent/Guardian/Qualified Person stating that Pursuant to section 33.25 of the Mental Hygiene Law, the enclosed documents shall not be further disseminated, EXCEPT that you may share the report with: (1) A Health Care Provider; (2) A Behavioral Health Care Provider; (3) Law Enforcement, if you believe a crime may have been committed; or (4) Your Attorney.
- Prior to mailing the records and documents, the Director of Quality Assurance or designee must ensure that any information tending to identify others involved in the allegation or investigation is redacted.
- Names or other information tending to identify anyone who made a report to the SCR of Child Abuse and Maltreatment must be protected.
- The Director of Quality Assurance or designee will ensure that a copy of the stamped envelope and the accompanying copies of the redacted records and documents are filed in the Quality Assurance investigative file.
- The Director of Quality Assurance or designee will notify a supervisor of the program via e-mail of the date that the records and documents were mailed out to the Parent/Guardian/ Qualified Person.
- The supervisor will document the date that the Director of Quality Assurance or designee mailed out the records and documents to the Parent/Guardian/Qualified Person on the Jonathan's Law forms.
- When SKHOV denies a request for the records and documents pertaining to allegations of abuse, SKHOV will inform the requestor in writing of the opportunity to appeal such denial to the OPWDD Incident Records Appeals Officer. SKHOV shall inform the requestor of the opportunity to send his or her written appeal to the OPWDD Incident Records Appeals Officer, Office of Counsel, 44 Holland Avenue, Albany, NY, 12229.

STATUS AND/OR FINDING PERTAINING TO ALLEGATIONS OF ABUSE

POLICY

- For allegations of abuse, SKHOV is required to offer to provide information on the status and/or finding of the allegation to the Parent/Guardian/ Qualified Person.
- Jonathan's law does not apply if the person who would otherwise be notified is the alleged abuser or if the Parent/Guardian/Spouse/Adult Child/Adult Sibling/Advocate/Correspondent objects to notification to himself or herself.
- Information on the status and/or finding of the allegation of abuse shall be provided verbally or in writing.
- Information on the status and/or finding of the allegation of abuse can include:
- Periodic updates regarding the status of the investigation. This should be brief. If the investigation is taking an unusually long time it could include a reason for the delay.
- A summary of findings.
- Results of the investigation: substantiated or unsubstantiated.
- Appropriate recommendations, especially those specific to the person receiving services, which are being implemented as a result of the allegation.

PROCEDURE

- During notification to the Parent/Guardian/ Qualified Person of an allegation of abuse pertaining to Jonathan's Law, the Parent/Guardian/ Qualified Person must be offered, verbally or in writing, information on the status

and/or finding of the investigation. The supervisor will document the date that the offer of the status and/or finding was accepted by the Parent/Guardian/ Qualified Person on the Jonathan's Law forms. If the offer was made in writing, a copy of the offer must be filed with the Jonathan's Law forms.

- If the Parent/ Guardian/ Qualified Person accepts the offer of the status and/or finding of the allegation, the supervisor will notify the Director of Quality Assurance or designee, via e-mail, that it was accepted.
- At the conclusion of the investigation, the assigned Quality Assurance investigator will forward the conclusion of the investigation (i.e. Substantiated or Unsubstantiated) and any corrective actions to a supervisor via e-mail. The supervisor will then notify the Parent/Guardian/Qualified Person of SKHOV's conclusion of the investigation and corrective actions either verbally or in writing. The supervisor will inform the Parent/Guardian/Qualified Person that SKHOV must submit its investigative findings to New York State for final review. The supervisor will also inform the Parent/Guardian/Qualified Person that if the State disagrees with SKHOV's findings, SKHOV will contact the family and provide them with the new finding. The supervisor will document the date that the status and/or finding of the investigation were provided to the Parent/Guardian/Qualified Person on the Jonathan's Law forms.

ADULT PROTECTIVE SERVICES

POLICY

- In situations involving alleged abuse of an adult 18 years or older who is currently receiving services and resides in a non-certified OPWDD facility, referrals to Adult Protective Services should only occur when effective investigation or intervention requires specific actions by Adult Protective Services related to legal actions or services which are unavailable in the OPWDD system. These include petitioning the court for an order to gain access or a short-term involuntary protective services order. Occasionally services not generally available in the OPWDD system, such as housekeeping, may be accessed through the Adult Protective Services. When an allegation of abuse takes place involving an individual 18 years or older and living with his/her parents and/or legal guardian, in which SKHOV needs to access information on certain records to effectively investigate or intervene, the Director of Quality Assurance will request that the appropriate DDSO seek to obtain the records from Adult Protective Services.

PROCEDURE

- The Quality Assurance Department will call the DDSO requesting that they call APS

AGENCY-WIDE INCIDENT REVIEW COMMITTEE

POLICY

- The SKHOV Incident Review Committee (IRC) reviews and monitors reportable incidents and notable occurrences that occur to people receiving services from our agency.
- The IRC reviews reportable incidents and notable occurrences to:

  (1) Ascertain that reportable incidents and notable occurrences were reported, managed, investigated and documented consistent with the provisions of Part 624 and with agency policies and procedures and to make written recommendations to the appropriate staff and/or the chief executive officer to correct, improve or eliminate inconsistencies;

  (2) Ascertain that necessary and appropriate corrective, preventive, remedial and/or disciplinary action has been taken to protect persons receiving services from further harm and to safeguard against the recurrence of similar reportable incidents and notable occurrences and to make written recommendations to the chief executive officer to correct, improve or eliminate inconsistencies;

  (3) Ascertain if further investigation or if additional corrective, preventive, remedial and/or disciplinary action is necessary, and if so, to make appropriate written recommendations to the chief executive officer relative to the reportable incident or notable occurrence;

  (4) Identify trends in reportable incidents and notable occurrences (e.g., by type, person, site, employee involvement, time, date, circumstances, etc.), and to recommend appropriate corrective, preventive, remedial and/or disciplinary action to the chief executive officer to safeguard against such recurring situations or reportable incidents and notable occurrences; and

(5) Ascertain and ensure the adequacy of the agency's reporting and review practices, including the monitoring of the implementation of approved recommendations for corrective, preventive, and remedial action.

The SKHOV IRC shall:

- Make written recommendations to appropriate staff to eliminate or minimize similar reportable incidents and/or notable occurrences in the future; and/or to improve investigatory or other procedures.
- Monitor actions taken on any and all recommendations made and advise the chief executive officer when there is a problem.
- Monitor trends of other events or situations attributable to a person receiving services which may be potentially harmful, but do not meet the definition of being a reportable incident or notable occurrence.
- Report periodically, but at least annually, to the chief executive officer, chief agency executives, the governing body, and OPWDD concerning the committee's general monitoring functions; general identified trends in reportable incidents [serious reportable incidents, and allegations of abuse] and notable occurrences; and corrective, preventive, remedial and/or disciplinary action pertaining to identified trends; and interact with the governing body and comply with the policies in relation to the review and monitoring of all reportable incidents and notable occurrences.
- Any committee member who recognizes a potential conflict of interest in his or her assignment shall report this information to the committee and excuse him or herself from participating in committee review of the incident or occurrence in question.
- No committee member may participate in the review of any reportable incident [, serious reportable incident, or alleged abuse] or notable occurrence in which he or she was directly involved, in which his or her testimony is incorporated, in which his or her spouse, domestic partner, or other immediate family member was directly involved, or which he or she investigated or participated in the investigation. Such members may, however, participate in committee deliberation regarding appropriate corrective, preventive, or remedial action.
- For reportable incidents and serious notable occurrences, no committee member may participate in the review of an investigation in which his or her spouse, domestic partner, or immediate family member provides supervision to the program where the incident took place or supervised directly involved parties.
- No committee member may participate in the review of a reportable incident or serious notable occurrence, if such committee member is the immediate supervisor of staff directly involved in the event or situation. Such member may, however, participate in committee deliberation regarding appropriate corrective, preventive or remedial action.

Role of the IRC when investigations are conducted by the Central Office of OPWDD or the Justice Center

Notwithstanding any other provision of Part 624, when an investigation of an incident or occurrence is conducted by the Central Office of OPWDD or the Justice Center:

- The IRC role in reviewing and monitoring the particular incident or occurrence is limited to matters involving compliance with the reporting and notification requirements of Part 624, protective and remedial actions taken (except disciplinary actions concerning services operated by OPWDD), operational concerns, and the quality of services provided.
- The finding (of the allegation of abuse) of substantiated or unsubstantiated shall be made by the Central Office of OPWDD or the Justice Center.
- The IRC shall monitor all actions taken to implement recommendations made by the Central Office of OPWDD or the Justice Center.

PROCEDURES

Incident Documentation Submission/Review & Meeting Agenda

- For all minor notable occurrences, serious notable occurrences, significant incidents and allegations of abuse that occur under the auspices of SKHOV (Part 624) or events/situations outside the auspices of SKHOV (Part 625) , copies of all incident documentation (e.g., 147, 149, Jonathan's law packet, monthly reports, and all other supporting documentation) must be sent to the IRC Chairperson via e-mail. The e-mail "subject" line should

indicate the name(s) of the individual(s) involved, the date that the incident was reported and the incident's classification.

- The IRC chairperson and/or corresponding investigator will transfer the information to all members to review prior to the next scheduled IRC meeting via email to the IRC Agency address (irc_agency@SKHOV.com).
- The IRC Chairperson will make copies of all of the incident documentation that needs to be reviewed and bring it to the next scheduled IRC meeting.
- Prior to each meeting, the IRC Chairperson will generate and distribute a meeting agenda to all IRC members, which includes the CEO and COO.
- The agenda will list the new incidents, monthly updates and final investigations that will be presented. The agenda will also indicate which documents need to be reviewed for each incident (e.g., 147, 149, Jonathan's law, monthly report or corrective actions).
- All IRC members are responsible to review the agenda to ensure that there have been no omissions of review-worthy information from their respective programs.

Information Requests

- Prior to each meeting, a request for information tracking sheet will be generated and distributed to all IRC members.
- The request for information tracking sheet will indicate what information the committee is requesting for previously presented incidents (e.g., proof that recommendation was completed, supporting documentation, etc.). The tracking sheet will also identify the person responsible for providing this information to the committee.
- Any information on the request for information tracking sheet will be reviewed when the corresponding incident is reviewed during the meeting and all requests for information will be collected from the IRC members, if still pending.
- Upon receipt of all requested information, the committee will close the incident.
- During the IRC meeting, after each review of an incident, the corresponding programs are informed of what information is being requested from them by the committee for that particular incident.
- Within five days of the meeting's conclusion, the request for information tracking sheet will be generated and distributed via email to the IRC members, including those staff that will be responsible for submitting the requested information once acquired.

Recommendations/Corrective Actions

- In order to ensure recommendations and corrective actions for incidents are carried out in a timely manner:
    - The following types of staff trainings/in-services should be completed as soon as possible (best practice is within two weeks of the IRC meeting): incident management, promoting positive relationships, ABC documentation, behavior plan, etc.
    - For the following types of staff trainings/in-services, when possible, the involved staff should attend the next scheduled training: SCIP-R, 1st Aid/CPR, AMAP, etc.
- In order to provide incident management training as a recommendation/corrective action for an incident in a timely manner, a representative from each department will conduct these trainings for their respective programs.

Document Revisions

- The IRC may sometimes request that an OPWDD 147, OPWDD 149 or other presented document be revised. A request for revision is made when a factual error, such as the spelling of a name or the date of an event, is present in a document reviewed by the IRC and is sent back to the investigator to be corrected. A revision is not the same as a rejection of a conclusion or recommendation; in the case of a revision there is a clear error whereas, in the case of a rejection, the committee acknowledges the information presented by the investigator and decides that it is not appropriate.
- If a revision is requested, the investigator is to revise the document per the IRC request. The revised document is to then be signed and dated with the date that the ORIGINAL document had been completed. Attached to that revised copy should be a memo stating what revision was made and on what date. This way, all of our investigative documents have the same, within compliance date on them, but any alterations are clearly recorded and displayed as to avoid any potential impropriety.

- When a revision is submitted with the appropriate memo that **did not yield a substantive change to either the conclusions or recommendations,** that revision has been completed and resolved with IRC.
- **If a revision yields a substantive change to either the conclusions or the recommendations**, then the new draft must be re-presented to IRC.
- A substantive change is defined as any alteration of the conclusions, findings or recommendations that definitively changes the meaning of the item, as written. For example, if an outdated BSP was used in the background information of a 149 (factual error to be revised) and the correct BSP contains new information that would lead the investigator to a different set of findings, that is a substantive change.

Meeting Minutes

- The IRC Chairperson ensures that minutes are kept/distributed for all meetings.
- For reportable incidents and serious notable occurrences, the portion of the minutes that discuss matters concerning the specific event or situation are entered into IRMA by the IRC Chairperson within three weeks of the meeting.
- Minutes addressing the review of specific reportable incidents and/or serious notable occurrences shall clearly state the filing number or identification code of the report, the person's full name and identification number (if used), and provide a brief summary of the situation (including date, location and type), that caused the report to be generated, committee findings (including reclassification of event, if applicable), and recommendations, and actions taken on the part of SKHOV as a result of such recommendations. Full names of all parties involved are to be recorded (not initials).
- Within two weeks of the meeting's conclusion, IRC meeting minutes for each incident, which include the incident findings and recommendations/corrective actions, will be distributed by the IRC Chairperson to all committee members, including the CEO and COO. In order to meet this requirement, the IRC Chairperson will place the meeting minutes into the "Incident Review Committee Folder" on the F drive which is only accessible to IRC members and Executive administrators. The IRC Chairperson will send out an email notifying all appropriate staff when the meeting minutes are placed into the IRC folder.
- Within three weeks of the meeting's conclusion, the IRC Chairperson will enter the IRC meeting minutes for all serious notable occurrences, significant incidents and allegations of abuse incidents into the Incident Reporting Management Application (IRMA).
- IRC meeting minutes will contain both the investigator's and IRC's recommendations/corrective actions, along with the staff responsible to ensure the completion/follow up of each recommendation/corrective action.
- If the IRC disagrees with a recommendation, it will be reflected in the IRC meeting minutes.
- If the IRC disagrees with an investigative conclusion (Substantiated or Unsubstantiated), it will be reflected in the IRC meeting minutes. Furthermore, the new IRC recommended investigative conclusion will be indicated.

Committee Requirements

- The IRC must meet within one month of the report/discovery of a serious notable occurrence, significant incident or allegation of abuse incident and within 90 days of the report/discovery of a minor notable occurrence. The IRC shall meet as necessary to meet the timeframes established for submission of a final report to the Justice Center for reportable incidents, if required.

Committee Attendance

- In order for the IRC to conduct any business, a quorum of members must be present. (See NYCRR Part 624 for the required makeup of the body of the IRC). Quorum is defined as the majority of departments having a representative present.
- Any member of the IRC may request the presence of another person at the committee meeting to provide information, such as an investigator being present to answer questions regarding his/her investigation.
- Any person must attend the IRC "Policy and Procedure" and "Confidentiality" trainings that comply with section 74 of the public officers law before attending a committee meeting

Program Incident Binder Maintenance

- Each SKHOV program will be responsible to maintain a binder consisting of all associated documents for each incident pertaining to their specific program. The associated documents include the following: IRC meeting

minutes/147s/149s/ Jonathan's lawpacket/monthly reports/associated incident documentation/verifying documentation for recommendations & corrective actions/etc.

- In order to ensure confidentiality, if the investigation involves management, then the incident information will be filed with the program's respective Director.
- The IRC Chairperson will be responsible to maintain both physical and electronic "backup" files consisting of all associated documentation for each incident presented.

INTERNAL INCIDENT REVIEW COMMITTEE

Policy:
It is the policy of SKHOV's Internal Incident Review Committee that if an incident/injury takes place under the auspices of the program and does not ascend to the level of a Minor Notable Incident or above, it will be documented and investigated as an Agency Occurrence. Agency Occurrences are comprised of injuries (both known and unknown origins), which do not require treatment beyond first aid and do not result in any positive medical test, if medical evaluation is sought. Additionally, this classification of incident includes medication errors with no adverse side effects, suspected theft or financial exploitation that is less than or equal to $15.00 in replacement value, that does not involve a debit, credit, or public benefit card, and that is an isolated occurrence, vehicle accidents that result in any medical visit; however does not require treatment beyond first aid and sensitive situations. It is the expectation that any staff member who becomes aware of an injury or incident that may fall under these classifications, report their findings to a supervisor.

Procedures:
Documentation of Agency Occurrence Investigations:

- Depending on the nature of an incident, an investigation will be conducted and documented on one of four forms. Attached to these forms should be any supporting documentation reviewed during the investigatory process (i.e. Behavior Support Plans, ABC Sheets, Body Checks, etc.)
    - The Known Origin form is used to provide the details of any incident or injury where the circumstances of the incident are clear to the investigator. This form will be used for injuries sustained while an individual engaged in a challenging behavior or SIB; however treatment is not more than first-aid, if an individual was injured by another individual; however treatment is not more than first-aid, any accidental injuries, vehicle accidents and sensitive situations.
    - The Unknown Origin form is used when an injury is discovered on an individual and it is unclear how the injury may have been sustained. In addition to the documents attached for the known origin incidents, these forms must include statements from any staff or individuals who may have had contact with the individual in the 24 hours prior to discovery OR from the last time it can be confirmed that the injury was not present on the individual.
    - The Medication Error Documentation form is used to document any instance where an individual did not properly receive their medication as they were prescribed by their physician and no adverse side effects occur. Some examples of medication errors include an individual not receiving their medication, receiving the wrong medication, receiving an improper dose of medication, or receiving their medication at the wrong time.
    - The Suspected Theft/Financial Exploitation form is used to document any suspected theft or financial exploitation of a service recipient's personal property that is less than or equal to $15.00 in replacement value, that does not involve a debit, credit, or public benefit card, and that is an isolated occurrence. any instance where an individual

Review Process for Agency Occurrences:

- The Agency Occurrences are presented to the Internal Incident Review Committee (IIRC) on at least a quarterly basis by a representative from each of the department's programs. The IIRC members have an opportunity to ask questions about the investigation and findings as well as make recommendations.
    - The IIRC Committee members (including an IIRC Chairperson) will make a determination as to

whether an internal incident can be closed or if it requires that the incident be re-presented at the following meeting with the recommended changes.

- Minutes will be generated by the IIRC Chairperson for each of the internal occurrences presented and will indicate whether or not the incident was able to be closed, closed with follow-up (while outlining what follow up was being requested), or if it required that the incident be re-presented at a future meeting.
- Proof of requested follow-up will be attached to the Minutes/Internal Occurrence for and will be kept on site.

INCIDENT MANAGEMENT- 625 Regulations

Part 625 Events and situations that are not under the auspices of SKHOV

Applicability

The requirements of the 625 regulation apply to events and situations that occur on or after June 30, 2013.

Section 625.2 Definitions

The following definitions apply to the terms as they are used in the regulation. Definitions for other terms used in the regulation may be found in the glossary in section 624.20 regulations.

a) Auspices, under the. For the purposes of the 625 regulation and Part 624, an event or situation in which SKHOV is providing services to a person. The event or situation can occur whether or not the person is physically at a site owned, leased, or operated by SKHOV.

(1) Events or situations that are under the auspices of SKHOV include but are not limited to:

(i) An event or situation in which SKHOV personnel (staff, interns, contractors, consultants, and/or volunteers) are, or should have been, physically present and providing services at that point in time.

(ii) Any situation involving physical conditions at the site provided by SKHOV, even in the absence of SKHOV personnel.

(iii) The death of an individual that occurred while the individual was receiving services or that was caused by or resulted from a reportable incident or notable occurrence defined in sections 624.3 and 624.4 of the regulations.

(iv) The death is also under the auspices of SKHOV if the death occurred up to 30 days after the discharge of the individual from the residential facility (unless the person was admitted to a different residential facility in the OPWDD system). (Note: this does not include free-standing respite facilities.)

(v) Related to reportable incidents and notable occurrences as defined in sections 624.3 and 624.4 of the regulations, any event that directly involves or may have involved SKHOV personnel.

(2) Events or situations that are not under the auspices of SKHOV include:

(i) Any event or situation that directly involves or may have involved SKHOV personnel during the time he or she was acting under the supervision of a State agency other than OPWDD (e.g. an agency employee has a second job at a hospital and an incident occurred while he or she was providing care to an individual receiving services during the individual's hospitalization).

(ii) Any event or situation that exclusively involves the family, friends, employers, or co-workers of an individual receiving services, whether or not in the presence of SKHOV personnel at a certified site.

(iii) Any event or situation that occurs in the context of the provision of services that are subject to the oversight of a State agency other than OPWDD (e.g. special education, article 28 clinic, hospital, physician's office), whether or not in the presence of SKHOV personnel.

(iv) Any allegation of neglect that is based on conditions in a private home.

(v) The death of an individual who received OPWDD operated, certified, or funded services, except deaths that occurred under the auspices of SKHOV as specified in paragraph (1) of this subdivision.

b) Physical abuse. The non-accidental use of force that results in bodily injury, pain or impairment, including but not limited to, being slapped, burned, cut, bruised or improperly physically restrained.
c) Sexual abuse. Non-consensual sexual contact of any kind, including but not limited to, forcing sexual contact or forcing sex with a third party.
d) Emotional abuse. The willful infliction of mental or emotional anguish by threat, humiliation, intimidation, or other abusive conduct, including but not limited to, frightening or isolating an adult.
e) Active neglect. The willful failure by the caregiver to fulfill the care-taking functions and responsibilities assumed by the caregiver, including but not limited to, abandonment, willful deprivation of food, water, heat, clean clothing and bedding, eyeglasses or dentures, or health related services.
f) Passive neglect. The non-willful failure of a caregiver to fulfill care-taking functions and responsibilities assumed by the caregiver, including but not limited to, abandonment or denial of food or health related services because of inadequate caregiver knowledge, infirmity, or disputing the value of prescribed services.
g) Self neglect. An adult's inability, due to physical and/or mental impairments, to perform tasks essential to caring for oneself, including but not limited to, providing essential food, clothing, shelter, and medical care; obtaining goods and services necessary to maintain physical health, mental health, emotional well-being, and general safety; or managing financial affairs.
h) Financial exploitation. The use of an adult's funds, property, or resources by another individual, including but not limited to, fraud, false pretenses, embezzlement, conspiracy, forgery, falsifying records, coerced property transfers, or denial of access to assets.
i) Death. The end of life, expected or unexpected, regardless of cause.

SKHOV involvement in events or situations that are not under the auspices of SKHOV.

(a) If SKHOV becomes aware of an event or situation involving an individual receiving services from SKHOV in which the event or situation is not under the auspices of SKHOV, SKHOV shall respond to the event or situation as follows:

(1) If the event or situation meets one of the definitions in sections 624.3 or 624.4 of the regulations (reportable incidents and notable occurrences) and occurred under the auspices of another agency subject to the requirements of Part 624 of the regulation:

(i) SKHOV shall comply with the requirements of subdivision 624.5(q) of the regulation. This includes the requirement to document the event or situation and report the situation to the agency under whose auspices the event or situation occurred.

(ii) Note that mandated reporters (e.g. custodians) are required to make reports to the Vulnerable Persons' Central Register (VPCR) pursuant to section 491 of the social services law. This means that mandated reporters at the discovering agency must report to the VPCR upon discovery of an allegation of a reportable incident that occurred in another program or facility which is certified or operated by OWPDD.

(2) If the event or situation meets one of the definitions in sections 624.3 or 624.4 of the regulation and occurred in a facility or service setting subject to the regulatory oversight of another State Agency (e.g. school, hospital), SKHOV shall document the event or situation and shall report the situation to the management of the facility or service setting.

(3) SKHOV shall intervene as specified in subdivision (b) of this section if it has reason to believe (e.g. a report or complaint is made to SKHOV, etc.) that the event or situation meets the definition of physical, sexual, or emotional abuse; active, passive, or self-neglect; or financial exploitation as defined in section 625.2 of the regulation, unless the event or situation meets the criteria in paragraphs (1) or (2) of this subdivision.

(4) Requirements concerning agency involvement in deaths that are not under the auspices of an agency are in section 625.5 of the regulation.

(b) SKHOV shall intervene in an event or situation that meets the definition of physical, sexual, or emotional abuse; active, passive, or self-neglect; or financial exploitation by taking actions to protect the involved individual with developmental disabilities. Such actions, as appropriate, may include but are not limited to the following:

(1) Notifying an appropriate party that may be in a position to address the event or situation (e.g. Statewide Central Register of Child Abuse and Maltreatment, Adult Protective Services, law enforcement officials, family members, school, hospital, or the Office of Professional Discipline);

(2) Offering to make referrals to appropriate service providers, clinicians, State agencies, or any other appropriate parties;

(3) Interviewing the involved individual and/or witnesses;

(4) Assessing and monitoring the individual;

(5) Reviewing records and other relevant documentation; and

(6) Educating the individual about his or her choices and options regarding the matter.

(c) SKHOV shall intervene as it deems necessary and appropriate (see subdivision (b) of this section for a list of interventions) when the event or situation meets the definition of physical, sexual, or emotional abuse; active, passive, or self-neglect; or financial exploitation, and involves an adult who meets the following criteria:

(1) The individual resides in a residence certified or operated by OPWDD (or a family care home);

(2) The individual receives day program services certified or operated by OPWDD;

(3) The individual receives Medicaid Service Coordination (MSC) or Plan of Care Support Services (PCSS) authorized by OPWDD; and/or

(4) The individual receives Home and Community Based Services (HCBS) waiver services authorized by OPWDD.

(d) SKHOV shall intervene by notifying Adult Protective Services of any event or situation that meets the definition of physical, sexual or emotional abuse; active, passive, or self-neglect; or financial exploitation, when it involves an adult receiving services who meets the following criteria:

(1) The individual is only receiving family support services (FSS), individual support services (ISS), or Article 16 clinic services; and/or

(2) The individual is not available to SKHOV or sponsoring agency; and/or

(3) The individual is in need of protective services that SKHOV cannot provide.

(e) Mandated reporters identified in Section 413 of the Social Services Law who are required to report cases of suspected child abuse or maltreatment shall report to the Statewide Central Register of Child Abuse and Maltreatment in accordance with the requirements of Article 6 of the Social Services Law.

(f) If more than one agency is providing services to the individual, there shall be a responsible agency that is designated to intervene in events or situations that meet the definition of physical, sexual, or emotional abuse; active, passive, or self-neglect; or financial exploitation.

(1) The agency is responsible for intervening shall be the provider of the services to the individual (or sponsoring agency) in the order stated:

(i) Residential facility, including a family care home (note: this does not include free-standing respite facilities);

(ii) Certified day program (if the individual is receiving services from more than one certified day program, the responsible agency shall be SKHOV that provides the greater duration of service on a regular basis);

(iii) MSC or PCSS;

(iv) HCBS Waiver services including respite services provided at a free standing respite facility or services under the Care at Home Waiver;

(v) FSS, ISS and/or Article 16 clinic services;

(vi) Any other service certified, operated, or funded by OPWDD.

(2) If the discovering agency is not the responsible agency, the discovering agency shall notify the responsible agency of the event or situation (unless it is sure that the responsible agency is already aware).

OPWDD involvement in events or situations that are not under the auspices of SKHOV.

(a) Reporting to OPWDD. SKHOV shall report events or situations in which actions were taken by SKHOV in accordance with the requirements of section 625.3 of the regulation as follows:

(1) SKHOV shall submit an initial report about the event or situation in the OPWDD Incident Report and Management Application (IRMA).

(2) SKHOV or sponsoring agency shall enter initial information about the event or situation within twenty-four hours of occurrence or discovery or by close of the next working day, whichever is later. Such initial information shall identify all actions taken by SKHOV, including any initial actions taken to protect the involved individual.

(3) SKHOV shall report updates on the event or situation in IRMA on a monthly basis or more frequently upon the request of OPWDD until the event or situation is resolved. Such updates shall include information about subsequent interventions (see subdivision 625.3(b)) and shall include information about the resolution of the event or situation.

(4) Requirements concerning OPWDD involvement in deaths that are not under the auspices of an agency are in section 625.5 of the regulation.

(b) Review/investigation by OPWDD.

(1) OPWDD has the right to investigate or review any event or situation regardless of the source of the information. SKHOV shall provide OPWDD reviewers or investigators with all relevant records, reports, and other information pertaining to the event or situation. Individuals receiving services, staff, and any other relevant parties may be interviewed in pursuit of any such review or investigation.

(2) When an event or situation is investigated or reviewed by OPWDD, OPWDD may make recommendations to SKHOV or sponsoring agency concerning any matter related to the event or situation. This may include recommendation that SKHOV conduct an investigation and/or take specific actions to intervene. In the event that OPWDD makes recommendations, SKHOV or sponsoring agency shall either:

(i) Implement each recommendation in a timely fashion and submit documentation of the implementation to OPWDD; or

(ii) In the event that SKHOV does not implement a particular recommendation, submit written justification to OPWDD within a month after the recommendation is made, and identify the alternative means that will be undertaken to address the issue, or explain why no action is needed.

Agency and OPWDD involvement in deaths that are not under the auspices of SKHOV.

(a) In accordance with New York State Law and guidance issued by the Justice Center, the death of any individual who had received services operated or certified by OPWDD, within thirty days preceding his or her death, and the death did not occur under the auspices of SKHOV, shall be reported to the Justice Center for the Protection of People with Special Needs (Justice Center), as follows:

(1) The initial report shall be submitted, by SKHOV's chief executive officer or designee, through a statewide, toll-free telephone number in a manner specified by the Justice Center.

(2) The initial report shall be submitted immediately upon discovery and in no case more than twenty-four hours after discovery.

(3) Subsequent information shall be submitted to the Justice Center, in a manner and on forms specified by the Justice Center, within five working days of discovery of the death.

(4) The results of an autopsy, if performed and if available to the provider agency, shall be submitted to the Justice Center within sixty working days of discovery of the death. (The Justice Center may extend the timeframe for good cause.)

(5) If more than one agency provided services to the individual, there shall be one responsible agency that is designated to report the death of the individual. The agency responsible for reporting to the Justice Center shall be the provider of the services to the individual in the order stated:

(i) OPWDD certified or operated day program (if the individual received services from more than one certified day program, the responsible agency shall be SKHOV that provided the greater duration of service on a regular basis);

(ii) MSC or PCSS (OPWDD operated services only);

(iii) HCBS Waiver services (OPWDD operated services only);

(iv) Care at Home Waiver services (OPWDD operated services only);
(v) Article 16 clinic services;
(vi) FSS or ISS (OPWDD operated services only);
(vii) Any other service operated by OPWDD.

Note: The requirements in this section do not apply to the death of an individual who received only OPWDD funded services (such as community habilitation or supported employment services) provided by a voluntary-operated agency, rather than services that are operated or certified by OPWDD, or to the death of an individual who resided in an OPWDD certified or operated residential program (see paragraph 625.2(a)(1) of the regulations).

(b) All deaths that are reported to the Justice Center shall also be reported to OPWDD.

(1) A death that occurred under the auspices of SKHOV (see paragraph 625.2(a)(1) of the regulation) shall be reported as a serious notable occurrence in accordance with Part 624 of the regulation.

(2) A death that did not occur under the auspices of SKHOV (see paragraph 625.2(a)(2) of the regulation) shall be reported in accordance with subdivision (c) of this section.

(c) The death of any individual who had received services certified, operated, or funded by OPWDD, within thirty days of his or her death, and the death did not occur under the auspices of SKHOV, shall be reported to OPWDD as follows:

(1) All deaths shall be reported immediately upon discovery to OPWDD by telephone or other appropriate methods. Immediate entry of initial information into the OPWDD Incident Report and Management Application (IRMA) shall not be sufficient to satisfy this requirement.

(2) SKHOV shall submit an initial report about the death in IRMA within twenty-four hours of discovery of the death, or by close of the next working day, whichever is later, in the form and format specified by OPWDD.

(3) SKHOV shall submit subsequent information about the death in IRMA within five working days following discovery of the death, in the form and format specified by OPWDD.

(4) If more than one agency provided services to an individual, there shall be one responsible agency that is designated to report the death of the individual. The agency responsible for reporting the death to OPWDD shall be the provider of the services to the individual (or sponsoring agency) in the order stated:

(i) OPWDD certified or operated day program (if the individual received services from more than one certified day program, the responsible agency shall be SKHOV that provided the greater duration of service on a regular basis);
(ii) OPWDD operated or funded MSC or PCSS;
(iii) OPWDD operated or funded HCBS Waiver services;
(iv) OPWDD operated or funded Care at Home Waiver services;
(v) Article 16 clinic services;
(vi) OPWDD operated or funded FSS or ISS services;
(vii) Any other service operated or funded by OPWDD.

(d) Investigations into deaths that did not occur under the auspices of SKHOV.

(1) The Justice Center has the right to investigate or review the death of any individual who had received services operated or certified by OPWDD, even if the death did not occur under the auspices of SKHOV. SKHOV shall provide Justice Center reviewers or investigators with all relevant records, reports, and other information pertaining to the event or situation. Individuals receiving services, staff, and any other relevant parties may be interviewed in pursuit of any such review or investigation.

(2) OPWDD has the right to investigate or review, or to request SKHOV to investigate, the death of any individual, even if the death did not occur under the auspices of SKHOV. SKHOV shall provide OPWDD reviewers or investigators with all relevant records, reports, and other information pertaining to the event or situation. Individuals receiving services, staff, and any other relevant parties may be interviewed in pursuit of any such review or investigation.

(3) If the Justice Center or OPWDD is responsible for the investigation, SKHOV shall fully cooperate with the assigned investigator.

PROCEDURES FOR 625 INCIDENTS

Reporting

- The staff person who observed or discovered the incident will immediately notify their supervisor.
- The supervisor will immediately ensure that notifications are made to SKHOV agency management up to the Chief Executive Officer or designee and the Quality Assurance Department.
- The Quality Assurance Department will notify the DDSO of the incident by entering the incident into IRMA within 24 hrs. of discovery.
- The supervisor will ensure that all other appropriate notifications (parent, Care Manager, corresponding programs and if applicable, law enforcement, Adult Protective Services, SCR, etc.) are made within 24 hours of the completion of the 150 incident report.
- For Willowbrook individuals, the program and the Quality Assurance Department will ensure that all required notifications are made.
- When an individual commits a possible criminal act or the individual is a victim of a crime, the Director of the program or designee will ensure that law enforcement have been notified of the incident immediately.
- For injuries, medication errors and death, the supervisor will ensure that the nurse is immediately notified.

Immediate Corrective Action(s)

- It is the responsibility of the staff that observed or discovered the incident to take whatever measures appear to be prudent to ensure the protection of the individual from further injury, harm, or abuse and prompt provision of treatment or care.
- It will be the responsibility of the Director of the program or designee where the incident occurred to take whatever measures appear to be prudent to ensure the protection of the individual from further injury, harm, and prompt provision of treatment or care. Additionally, they will ensure appropriate follow up is implemented which could include, providing counseling, conducting a body check, etc.

Investigative Process

- The Quality Assurance Department will immediately begin investigating the incident.
- For injuries unknown origin, all persons having contact with the individual within 24 hours prior to the discovery of the injury, must be interviewed.
- For individuals residing in an ICF, the Quality Assurance Department will complete and forward the investigation to the Chief Executive Officer or designee within five working days of the occurrence or discovery of the incident.
- The investigation must be complete within 30 days of the occurrence or discovery of the incident. However, if the investigation is not completed within 30 days, there must be written justification as to why it exceeded 30 days. This justification should be documented in a monthly investigative report.
- If the investigation is not complete within 30 days, the assigned investigator will be responsible to enter a monthly update into IRMA until the incident is closed.
- The assigned investigator will enter a brief review to the summary of evidence and whatever specific investigatory actions were taken since the last update that was entered into IRMA.
- If there have been no additions to the summary of evidence or investigatory actions taken since the last report, the assigned investigation must specify in IRMA why no progress was made.

Documentation

- The supervisor will document the OPWDD 150 incident report, excluding notifications, within 24 hours of the occurrence or discovery of the incident.
- The supervisor will immediately forward the OPWDD 150 incident report to the IRC Chairperson.

- The IRC Chairperson will enter the designated information from the OPWDD 150 incident report, specified by OPWDD, into the Incident Report and Management Application (IRMA) within 24 hours of the occurrence or discovery of the incident. However, if unable to enter the information into IRMA within 24 hours of the occurrence or discovery due to weekend or holiday, the information may be entered until no later than the close of the next business day. In this event, the OPWDD 150 incident report must be completed and submitted to the IMU within 24 hours of the occurrence or discovery of the incident.
- The supervisor will document all notifications (parent, Care Manager, RN, corresponding programs, etc.) within 24 hours of the completion of the OPWDD 150 incident report.
- The supervisor will immediately forward the completed notifications to the IRC Chairperson. The IRC Chairperson will then enter this information into IRMA within 24 hours of the occurrence or discovery of the incident.
- For Willowbrook individuals, the IRC Chairperson will submit the completed OPWDD 150 incident report to the appropriate Willowbrook representatives.
- The IRC Chairperson will submit the completed OPWDD 150 incident report and investigation to the SKHOV Wide Incident Review Committee within 30 days of the occurrence or discovery of the incident.

Follow-Up

- The OPWDD 150 incident report and the investigation will be presented to SKHOV Wide Incident Review Committee for review within 30 days of the occurrence or discovery of the incident. If after 30 days, the incident is still under investigation, an investigative update will be presented. Additional investigative findings will be presented at each meeting until the committee closes the case.
- The case will remain open until all requested information has been submitted to SKHOV Wide Incident Review Committee chairperson, and the Committee's review of the matter is satisfied.
- Within 30 days of the occurrence or discovery of the incident, the IRC Chairperson will enter the final investigation into IRMA. If the investigation is not completed within 30 days, the IRC Chairperson will keep IMU informed in writing, through IRMA, of the progress of the investigation every 30 days until the investigation is completed.
- SKHOV Wide Incident Review Committee Chairperson will forward any findings/recommendations to the Chief Executive Officer or designee within two weeks of each review of the incident.
- SKHOV Wide Incident Review Committee Chairperson will enter the meeting minutes pertaining to the incident into IRMA within three weeks of the review of the incident.