



## **Incident Management and Review Policy**

REGULATION: 14 NYCRR Parts 624 and 625 (Emergency Regulations (Effective September 17, 2014))

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BOARD APPROVAL: Pending Approval

It is the policy of Toomey Residential and Community Services to report, investigate, review, correct and/or monitor certain events or situations to enhance the quality of care provided to persons with developmental disabilities, to protect them (to the extent possible) from harm, and to ensure that such persons are free from abuse and neglect.

Procedures have been developed and will be followed by all persons who work or volunteer for Toomey Residential and Community Services. The primary function of the reporting of certain events or situations is to enable a governing body, executives, administrators, and supervisors to become aware of problems; to take corrective measures; and to minimize the potential for recurrence of the same or similar events or situations. The prompt reporting of these events or situations can ensure that immediate steps are taken to protect persons receiving services from being exposed to the same or similar risk. The reporting of certain events in an orderly and uniform manner facilitates the identification of trends, which ultimately allows for the development and implementation of preventive strategies.

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## I. Applicability

The policy applies to all facilities and programs that are operated, certified, sponsored or funded by the Office for People with Developmental Disabilities (OPWDD) for the provision of services to persons with developmental disabilities.

The following programs provided by Toomey Residential and Community Services are certified by OPWDD:

- Individualized Residential Alternatives; and,
- Intermediate Care Facilities

The following programs provided by Toomey Residential and Community Services are funded by OPWDD:

- Medicaid Service Coordination
- Community Habilitation; and,
- Day Habilitation

Intermediate Care Facilities must also comply with the requirements of 42 CFR 483. In some instances, these federal requirements are more stringent than the requirements of this Part.

Requirements of Part 624 (reportable incidents and notable occurrences) apply to events and situations that are under the auspices (see glossary) of an agency. Requirements concerning events and situations not under the auspices of an agency are set forth in Part 625.

Requirements are applicable to incidents that occur on and after June 30, 2013. Incidents that occurred prior to this date are subject to the requirements that were in effect at the time the incidents occurred.

## **II. Immediate Protections**

A person's safety must always be the primary concern of Toomey Residential and Community Services chief executive officer (or designee). He or she shall take necessary and reasonable steps to ensure that a person receiving services who has been harmed receives any necessary treatment or care and, to the extent possible, take reasonable and prudent measures to immediately protect individuals receiving services from harm and abuse.

When appropriate, an employee, intern, volunteer, consultant, or contractor alleged to have abused or neglected a person shall be removed from direct contact with, or responsibility for, all persons receiving services from the agency.

When appropriate, an individual receiving services shall be removed from a facility when it is determined that there is a risk to such individual if he or she continues to remain in the facility.

### III. Identifying Part 624 Incidents

Reportable incidents are events or situations that meet the definitions of this section and are under the auspices of the agency.

#### **Reportable incidents, defined.**

- 1) **Physical abuse** shall mean conduct by a custodian (see glossary) intentionally (see glossary) or recklessly (see glossary) causing, by physical contact, physical injury (see glossary) or serious or protracted impairment of the physical, mental, or emotional condition of the individual receiving services, 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 party.
- 2) **Sexual abuse** 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, or any conduct or communication by such custodian that allows, permits, uses, or encourages a person receiving services to engage in any act described in articles 230 or 263 of the penal law; and/or

Any sexual contact between an individual receiving services and a custodian of the program or facility which provides services to that individual whether or not the sexual contact would constitute a crime (see especially section 130.05(i) of the penal law). However, if the individual receiving services is married to the custodian the sexual contact shall not be considered sexual abuse. Further, for purposes of this subparagraph only, a person with a developmental disability who is or was receiving services and is also an employee or volunteer of an agency shall not be considered a custodian if he or she has sexual contact with another individual receiving services who is a consenting adult who has consented to such contact.

- 3) **Psychological abuse** includes any verbal or nonverbal conduct that may cause significant emotional distress to an individual receiving services.

Examples include, but are not limited to, taunts, derogatory comments or ridicule, intimidation, threats, or the display of a weapon or other object that could reasonably be perceived by an individual receiving services as a means for infliction of pain or injury, in a manner that constitutes a threat of physical pain or injury.

In order for a case of psychological abuse to be substantiated after it has been reported, the conduct must be shown to intentionally or recklessly cause, or be likely to cause, a substantial diminution of the emotional, social or behavioral development or condition of the individual receiving services. Evidence of such an effect must be supported by a clinical assessment performed by a physician, psychologist, psychiatric nurse practitioner, licensed clinical or master social worker or licensed mental health counselor.

- 4) **Deliberate inappropriate use of restraints** 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 an individual's plan of services (e.g. individualized service plan (ISP) or a habilitation plan), or behavior support 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 party. For purposes of this paragraph, 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.

- 5) **Use of aversive conditioning** 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. Aversive conditioning may include, but is not limited to, the use of physical stimuli such as noxious odors, noxious tastes, blindfolds, and the withholding of meals and the provision of substitute foods in an unpalatable form. The use of aversive conditioning is prohibited by OPWDD.
- 6) **Obstruction of reports of reportable incidents** 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 the safety, treatment, or supervision of an individual receiving services; actively persuading a custodian or other mandated reporter (as defined in section 488 of the Social Services Law) from making a report of a reportable incident to the statewide vulnerable persons' central register (VPCR) or OPWDD 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 OPWDD regulations, policies or procedures; or, for a custodian, failing to report a reportable incident upon discovery.
- 7) **Unlawful use or administration of a controlled substance** shall mean any administration by a custodian to a service recipient of a controlled substance as defined by article 33 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 33 of the public health law, at the workplace or while on duty.
- 8) **Neglect** 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 (1) through (7) of this subdivision if committed by a custodian;
  - (ii) **failure to provide adequate food, clothing, shelter, or medical, dental, optometric or surgical care**, consistent with Parts 633, 635, and 686, of this Title (and 42 CFR Part 483, applicable to Intermediate Care Facilities), and provided that the agency 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 parties;
  - (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.
- 9) **Significant incident** shall mean 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:

- (i) **Conduct between persons receiving services** that would constitute abuse if committed by a custodian, except sexual activity involving adults who are capable of consenting and consent to the activity; or
- (ii) **Conduct on the part of a custodian, that is inconsistent with the individual's plan of services**, 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:
  - a) **Seclusion**, which means the placement of an individual receiving services in a room or area from which he or she cannot, or perceives that he or she cannot, leave at will except when such placement is specifically permitted by section 633.16 of this Title.
  - b) **Unauthorized use of time-out**, which means 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, for disciplinary purposes, or as a substitute for programming.
  - c) **The 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 an individual receiving services. For purposes of this clause, "adverse effect" shall mean the unanticipated and undesirable side effect from the administration of a particular medication which unfavorably affects the wellbeing of a person receiving services; and
  - d) **Inappropriate use of restraints**, which means 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) **Other mistreatment**, which means other conduct on the part of a custodian, that is inconsistent with the individual's plan of services, generally accepted treatment practices, and/or applicable federal or state laws, regulations or policies, and which impairs or creates a reasonable foreseeable potential to impair the health, safety, or welfare of an individual receiving services.
- (iii) **Missing person** which means 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; or
- (iv) **Choking, with known risk** which means 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; or
- (v) **Self-abusive behavior, with injury**, which shall mean a self-inflicted injury to an individual receiving services that requires medical care beyond first aid.

## **Notable Occurrences, defined.**

Notable occurrences shall not include events and situations that meet the definition of a reportable incident. An exception is that deaths that also meet the definition of a reportable incident shall be reported both as the reportable incident and as a notable occurrence.

Notable occurrences are events or situations that meet the definitions of this section and occur under the auspices of the agency. Minor and serious notable occurrences are defined and categorized as follows:

### **1) Injury.**

- (i) **Minor notable occurrence.** Any suspected or confirmed harm, hurt, or damage to an individual receiving services, caused by an act of that individual or another, whether or not by accident, and whether or not the cause can be identified, that results in an individual requiring medical or dental treatment (see glossary, section 624.20) by a physician, dentist, physician's assistant, or nurse practitioner, and such treatment is more than first aid. Illness in itself shall not be reported as an injury or any other type of incident or occurrence.
- (ii) **Serious notable occurrence.** Any injury that results in the admission of a person to a hospital for treatment or observation because of injury.

Note: In accordance with subparagraph 624.3(b)(9)(v) an injury due to self-injurious behavior that requires medical care beyond first aid is a "reportable incident."

- 2) **Unauthorized absence.** The unexpected or unauthorized absence of a person after formal search procedures (see glossary) have been initiated by the agency. Reasoned 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 wellbeing of the person or others. Any unauthorized absence event is considered a serious notable occurrence.

- 3) **Death.** The death of any person receiving services, regardless of the cause of death, is a serious notable occurrence. This includes all deaths of individuals who live in residential facilities operated or certified by OPWDD and other deaths that occur under the auspices of an agency.

- 4) **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, other than a "reportable" choking, with known risk, incident (see subparagraph 624.3(b)(9)(iv) of this Part), involving an individual with a known risk for choking and a written directive addressing that risk. Any choking with no known risk event is considered a serious notable occurrence.

### **5) Theft and financial exploitation.**

- (i) **Minor notable occurrence.** Any suspected theft of a service recipient's personal property (including personal funds or belongings) or financial exploitation, involving values of more than \$15.00 and less than or equal to \$100.00, that does not involve a credit, debit, or public benefit card, and that is an isolated event.
- (ii) **Serious notable occurrence.** Any suspected theft of a service recipient's personal property (including personal funds or belongings) or financial exploitation, involving a value of more than \$100.00; theft involving a service recipient's credit, debit, or public benefit card (regardless of

the amount involved); or a pattern of theft or financial exploitation involving the property of one or more individuals receiving services.

- 6) **Sensitive situations.** Those situations involving a person receiving services that do not meet the criteria of the definitions in paragraphs (1) – (5) of this subdivision or the definitions of reportable incidents as defined in section 624.3 of this Part, that may be of a delicate nature to the agency, and are reported to ensure awareness of the circumstances. Sensitive situations shall be defined in agency policies and procedures, and shall include, but not be limited to, possible criminal acts committed by an individual receiving services. Sensitive situations are serious notable occurrences.
- 7) **ICF Violations.** Events and situations concerning residents of Intermediate Care Facilities (ICFs) that are identified as violations in federal regulation applicable to ICFs and do not meet the definitions of reportable incidents or notable occurrences. ICF violations are serious notable occurrences.

#### **IV. Non-reportable Incidents**

A non-reportable incident is a significant occurrence or event which is not required to be reported to OPWDD, that is, which does not meet the definitions given above for a reportable incident or notable occurrence, but should be brought to the attention of program administration. Non-reportable incidents include, but are not limited to:

- Minor injuries or falls which require only simple first aid or less (or a check for injuries)
- Any mistakes administering medications or forgetting to administer medications which could jeopardize a person's health or well-being, but do not result in any marked adverse effect.

A record of incidents which are not reportable will be maintained by each program on the Non-Reportable Incident Log. This log will be reviewed daily by the Program Coordinator and a written report containing information relative to trends, patterns, and corrective measures possible and taken and a review of the decisions made in establishing the difference between a non-reportable incident, will be submitted to the Program Director monthly.

There may be events that initially are reported as non-reportable incidents, but due to additional circumstances, may become a reportable incident or notable occurrence. In this case, the re-classification would initiate a different process relevant to the type of re-classification. Any significant issues regarding re-classification of an incident will be reviewed at the following agency Incident Review Meeting and recommendations will be reflected in the minutes. The Program Director will monitor trends and training needs in conjunction with Program Coordinators and take corrective action as necessary.

## **V. Reporting Incidents**

### **Notification of policies and procedures.**

Upon commencement of service provision, and annually thereafter, Toomey Residential and Community Services, shall offer to make available written information, developed by OPWDD in collaboration with the Justice Center for the Protection of People with Special Needs (Justice Center), and a copy of the agency's policies and procedures, to persons receiving services who have the capacity to understand the information and to their parents, guardians, correspondents (see glossary) or advocates (see glossary), unless a person is a capable adult who objects to their notification. Toomey Residential and Community Services shall also offer to make available a copy of OPWDD's Part 624 regulations.

In order to satisfy this requirement Toomey Residential and Community Services shall provide instructions on how to access such information in electronic format and, upon written request, provide paper copies of such information. Toomey Residential and Community Services will use the OPWDD "Learning About Incidents" brochure for both purposes.

Upon employment or initial volunteer, contract, or sponsorship arrangements, and annually thereafter, Toomey Residential and Community Services, shall make the agency's policies and procedures on incident management known to agency employees, interns, volunteers, consultants, contractors, and family care providers.

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 reporting requirements.**

All Toomey Residential and Community Services employees, interns, volunteers, consultants, contractors, and family care providers are required to report any event or situation that meets the criteria of a reportable incident or notable occurrence as defined in this Part. Custodians of programs and facilities certified or operated by OPWDD are mandated reporters and are also required to report reportable incidents pursuant to section 491 of the Social Services Law. Reports shall be made in accordance with Toomey Residential and Community Services policies/procedures.

### **Internal agency reporting.**

All minor notable occurrences, as defined above, shall be reported to Toomey Residential and Community Services chief executive officer (or designee) within 48 hours upon occurrence or discovery.

All reportable incidents, as defined above, and serious notable occurrences, as defined above, shall be reported to Toomey Residential and Community Services chief executive officer (or designee) immediately upon occurrence or discovery.

### **Immediate reporting to OPWDD.**

All reportable incidents and serious notable occurrences shall be reported immediately to OPWDD in the manner specified by OPWDD. Immediate entry of initial information into the OPWDD Incident Report and Management Application (IRMA) shall not be sufficient to satisfy this requirement.

## **Reporting of reportable incidents to the Vulnerable Persons' Central Register (VPCR).**

Facilities and programs that are operated or certified by OPWDD shall report all reportable incidents to the VPCR. Non-certified programs that are not state operated are not required to report to the VPCR. Only reportable incidents are required to be reported to the VPCR (not notable occurrences).

All custodians (see glossary) in programs or facilities operated or certified by OPWDD are “mandated reporters” and are required to report reportable incidents to the VPCR.

All custodians in programs or facilities operated or certified by OPWDD shall submit reports of reportable incidents to the VPCR immediately upon discovery of the reportable incident:

- “Discovery” occurs when the mandated reporter witnesses a suspected reportable incident or when another party, including an individual receiving services, comes before the mandated reporter in the mandated reporter's professional or official capacity and provides the mandated reporter with reasonable cause to suspect that the individual has been subjected to a reportable incident.
- Reports shall be submitted by a statewide, toll-free telephone number (a “hotline”) or by electronic transmission, in a manner and on forms prescribed by the Justice Center.
- A report to the VPCR shall include the name, title, and contact information of every person known to the mandated reporter to have the same information as the mandated reporter concerning the reportable incident.
- Mandated reporters shall have the rights and responsibilities established by section 491 of the social services law.
- The obligation of mandated reporters to report reportable incidents to the VPCR is not limited to reportable incidents occurring at the agency with which the mandated reporter is associated. If the mandated reporter becomes aware that an individual has been subjected to a reportable incident at a different facility or program subject to the requirements of Article 11 of the social services law, the mandated reporter is also required to report the incident to the VPCR. Facilities and programs subject to Article 11 include but are not limited to facilities and programs certified or operated by OPWDD, facilities under the oversight of the Office of Mental Health (OMH), specified residential schools (e.g. “853 schools” and “4201” schools), and summer camp.

In a case where a subject of a report of abuse or neglect in a program certified or operated by OPWDD resigns from his or her position or is terminated while under investigation, the agency shall promptly report such resignation or termination to the Justice Center.

## **Reporting deaths.**

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. The initial report shall:

- Be submitted by the Toomey Residential and Community Services chief executive officer or designee, through a statewide, toll-free telephone number, in a manner specified by the Justice Center.
- Be submitted immediately upon discovery and in no case more than twenty-four hours after discovery.

Subsequent information:

- To 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.
- The results of an autopsy, if performed and if available to the agency, is to 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.)

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 is reported as a serious notable occurrence. 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) is reported in accordance with Part 625 of this Title.

The death of any individual who had received services certified, operated, or funded by OPWDD, and the death occurred under the auspices of the agency shall be classified as a serious notable occurrence, and reported and managed as such, in accordance with the requirements of Part 624.

## **VI. Reporting to OPWDD: Required Reporting Formats**

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

Information must be entered into IRMA for reportable 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.

When a report of a reportable incident or a serious notable occurrence is made to the Justice Center (VPCR), initial information is automatically entered into IRMA; however, Toomey Residential and Community Services is required to review the information within 24 hours of occurrence or discovery of the incident 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 within 24 hours of occurrence or discovery or by close of the next working day, whichever is later.

#### **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 identifies a different timeframe for the entry of specific information, Toomey Residential and Community Services must comply with that timeframe requirement instead. Specific timeframes are identified in provisions concerning:
  - Reporting updates (see Part 624.5)
  - Notification of law enforcement officials (see Part 624.6)
  - Minutes of incident review committee (IRC) meetings (see Part 624.7).
- Toomey Residential and Community Services 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. Toomey Residential and Community Services shall comply with all requests by OPWDD for the entry of specific subsequent information.

**Written initial incident/occurrence report.**

*Minor notable occurrences:* Toomey Residential and Community Services may enter information about minor notable occurrences into IRMA in lieu of completing a written initial incident/occurrence report. Within 48 hours of occurrence or discovery or by close of the next working day, whichever is later, Toomey Residential and Community Services shall either:

- complete a written initial incident/occurrence report in the form and format specified by OPWDD (we use OPWDD Form 147; or,
- Enter initial information into IRMA.

To comply with any requirement that Toomey Residential and Community Services send or disclose a copy of the written initial incident/occurrence report (e.g. in Part 624.6) the agency shall send or disclose either:

- a copy of the written initial incident/occurrence report completed by Toomey Residential and Community Services (with redaction if required); or,
- a written initial incident/occurrence report printed from IRMA (with redaction if required)

## **VII. Notifications**

### **Mental Hygiene Legal Service.**

For a report of abuse or neglect involving a person who resides in a facility certified or operated by OPWDD, the agency under whose auspices the event occurred and/or that is responsible for the person shall send the written initial incident/occurrence report to the Mental Hygiene Legal Service within three working days of occurrence or discovery. The responsible agency or program shall inform MHLS of the results of the investigation.

### **Coroner/Medical Examiner.**

All suicides, homicides, accidental deaths, or deaths due to suspicious, unusual, or unnatural circumstances must be reported immediately by telephone and later in writing, to the coroner/medical examiner.

### **Law Enforcement.**

An appropriate law enforcement official must be contacted immediately in the event that an emergency response by law enforcement is needed.

Toomey Residential and Community Services 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.

### **Guardian/Parent/Spouse/Adult Child.**

*For all reportable incidents and notable occurrences:*

- 1) Toomey Residential and Community Services shall provide telephone notice to one of the following: a person's guardian, a parent, spouse or adult child.
- 2) However, the agency shall not provide such notice to a party in the following situations:
  - there is written advice from the guardian, parent, spouse or adult child that he or she objects to such notification to himself or herself (notice shall then be provided to another party who is a guardian, parent, spouse or adult child, if one exists); or
  - if the person receiving services is a capable adult who objects to such notification being made. If the capable adult objects to notification of all parties who are a guardian, parent, spouse or adult child, the capable adult shall be provided the notice described in this subdivision; or
  - if the guardian, parent, spouse or adult child is the alleged abuser.

- 3) The telephone notice shall be provided as soon as reasonably possible, but no later than 24 hours after completion of the written initial incident/occurrence report (for minor notable occurrences) or entry of initial information in IRMA by Toomey Residential and Community Services.
- 4) The telephone notice shall include:
  - a description of the event or situation and a description of initial actions taken to address the incident or occurrence, if any;
  - an offer to meet with the chief executive officer (or designee) to further discuss the incident or occurrence; and
  - for reports of abuse and neglect, an offer to provide information on the status and/or finding of the report. Requested information shall be provided verbally or in writing, unless the person is a capable adult and objects to the provision of this information. In providing such information, the agency shall protect the privacy rights of other parties.
- 5) Methods of notification:
  - The complete telephone notice may be comprised of more than one call, so long as the initial call includes a description of the event or situation and is within the required period of time or is attempted within the required period of time. Follow-up calls with the additional required information shall be made within a reasonable timeframe after the initial call.
  - Notice may be made in person instead of by telephone.
  - Notice may be provided by other methods at the request of the party receiving notice.
- 6) If the person does not have a guardian, parent, spouse or adult child, or if such parties are not reasonably available, or if there is written advice that such parties do not want to be notified; Toomey Residential and Community Services shall provide notice to the following parties in the manner (and subject to the same limitations):
  - the person receiving services, if the person is a capable adult; and
  - the person's advocate or correspondent (if one exists).

### **Service Coordinator.**

The individual's service coordinator (e.g. a Medicaid Service Coordinator or Plan of Care Support Services Service Coordinator) must be notified by Toomey Residential and Community Services of all reportable incidents and notable occurrences involving any individual receiving non-ICF services that are certified, funded, or operated by OPWDD and must be provided with subsequent information, as follows:

- The service coordinator must be notified within 24 hours of the completion of the written initial incident/occurrence report (for minor notable occurrences) or entry of initial information in IRMA by Toomey Residential and Community Services. The notification must include a description of immediate protections.
- The service coordinator must be provided with subsequent information that may be needed to update an individual's plan of services and to monitor protective, corrective, and other actions taken following a reportable incident or occurrence. Specifically:
- The service coordinator must be provided with written information identifying investigative conclusions (including the findings of a report of abuse or neglect) and recommendations pertaining to the individual's care, protection, and treatment. The information provided must exclude information that directly or indirectly identifies Toomey Residential and Community Services employees, consultants, contractors, volunteers, or other individuals receiving services. This information must be provided to the service coordinator within:

- 10 days following completion of the investigation if the investigation was conducted by Toomey Residential and Community Services; or,
- 10 days after the agency receives notice of the results of an investigation conducted by Central Office of OPWDD or the Justice Center.
- If the IRC review results in additional findings, conclusions, or recommendations regarding the individual's care, protection, and/or treatment, this information must be provided to the service coordinator, in written form, within 3 weeks.
- If the Justice Center's review of an investigation conducted by the agency or by the Central Office of OPWDD results in additional findings, conclusions, or recommendations regarding the individual's care, protection, and/or treatment, this information must be provided to the service coordinator, in written form, within 10 days after the agency's receipt of the information.
- The service coordinator may request additional information concerning the incident or occurrence in order to monitor protective, corrective, and/or other actions taken. In the event that Toomey Residential and Community Services receives a request for this information from a service coordinator, Toomey Residential and Community Services shall provide information that it deems appropriate. In providing this information, Toomey Residential and Community Services must exclude information that directly or indirectly identifies agency employees, consultants, contractors, volunteers, and other individuals receiving services. If Toomey Residential and Community Services determines that it would be inappropriate to disclose specific information requested, Toomey Residential and Community Services must advise the service coordinator of this determination and its justification, in writing, within 10 days following the request. If Toomey Residential and Community Services does not have specific information requested by the service coordinator (e.g. if the Justice Center conducted the investigation and it has not provided that information to the agency) the agency shall advise the service coordinator that it does not have the requested information.
- If the service coordinator is identified as the subject of a report of abuse or neglect or as a witness to a reportable incident or occurrence, Toomey Residential and Community Services shall not provide information to that party. In such a case, notifications and written information as noted above must be provided to the service coordinator's supervisor or the administrator of the agency providing service coordination in lieu of the service coordinator.

The individual's Qualified Intellectual Disabilities Professional (QIDP) and (if the person is a Willowbrook class member), the Willowbrook Case Services Coordinator (WCSC) must also be notified by the agency of all reportable incidents and occurrences involving any individual who resides in an Intermediate Care Facility that is operated or certified by OPWDD. The QIDP and WCSC must also be provided with subsequent information. Information to the QIDP and WCSC shall be provided in the same manner that the information is provided to the Non-ICF service coordinator. If the QIDP or WCSC is identified as the alleged abuser, or is a witness to an incident or alleged abuse, the required notifications and subsequent information must be provided to the QIDP's or WCSC's supervisor or administrator of the agency providing residential or WCSC services in lieu of the QIDP or WCSC.

Note: A service coordinator (including a QIDP performing that function) may be permitted to access information related to substantiated reports in accordance with section 496(2)n of Social Services Law.

## **Other agencies.**

It is the responsibility of a designated staff member of the agency 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.

## **Requests for the written initial incident/occurrence report.**

*Process:* Requests may be made for a copy of the written initial incident/occurrence report by the person receiving services (or who formerly received services), guardian, parent(s), or correspondent/advocate. Such request shall be in writing. However, at the discretion of the agency, documented verbal requests may be accepted in lieu of a written request. If the person is a capable adult and objects to the provision of the written initial incident/occurrence report, such report shall not be provided to otherwise eligible requestors. If an otherwise eligible requestor is the alleged abuser, the written initial incident/occurrence report shall not be provided to that requestor.

*Redaction:* The copy of the report shall incorporate redaction of the names of employees who are involved in the incident or occurrence or the investigation or who are interviewed as a part of the investigation, persons receiving services (or who formerly received services), and any information tending to identify such employees or persons. Redaction shall be waived if the employee or person authorizes disclosure, unless redaction of the specific information is necessary because it tends to identify another employee or person who has not authorized disclosure or for another reason specified in this subparagraph.

In addition, if the report identifies a particular party as having made a child abuse or maltreatment report to the Statewide Central Register of Child Abuse and Maltreatment (SCR), contacted the SCR, or otherwise cooperated in a child abuse/maltreatment investigation, that name as well as any information tending to identify the party shall be redacted.

The copy of the written initial incident/occurrence report shall be provided to an eligible requestor as soon as reasonable, but in no event more than 10 days after the request is made. The copy of the written initial incident/occurrence report shall be accompanied by a statement that all contents are preliminary and have not been substantiated.

*Report on actions taken:* Toomey Residential and Community Services shall provide a report on initial actions taken to address the incident or notable occurrence. Such report shall include:

- any immediate steps taken in response to the incident or occurrence to safeguard the health or safety of the person receiving services; and
- a general description of any initial medical or dental treatment or counseling provided to the person in response to the incident or occurrence.

Toomey Residential and Community Services shall provide the report on actions taken to any party who received this notification (i.e., the person's guardian, a parent, spouse or adult child).

The report shall be provided within 10 days of the completion of the written initial incident/occurrence report (for minor notable occurrences) or entry of initial information in IRMA by Toomey Residential and Community Services.

The report that is provided shall be in the form and format specified by OPWDD (e.g. OPWDD 148) or in a similar format developed by Toomey Residential and Community Services.

The report that is provided shall not include names of anyone who is involved in the incident or occurrence or the investigation, or who is interviewed as a part of the investigation, or any information tending to identify such parties. Names of any such parties as well as any information tending to identify those parties shall be excluded or redacted.

*Documentation maintenance:* The following documentation shall be maintained:

- the telephone notice and responses received, including the identity and position of the party providing the notice, the name of the party receiving the notice, the time of the original call or attempted call, the time of subsequent attempted calls if the initial call was not successful and the time of follow up calls if the notice occurred in more than one call.
- any requests for a meeting or the written initial incident/occurrence report ;
- meetings held in response to the request, and those present;
- when the report on actions taken and any requested written initial incident/occurrence report was provided;
- a copy of the report on actions taken and any written initial incident/occurrence report (with redaction) that was provided; and
- advice that a particular party does not want to receive notifications or that the capable adult receiving services objects to notice or objects to the provision of documents/information.

For the purpose of redaction, the term employee means any party who is, or was

- directly employed by an agency; or
- used by an agency to provide services substantially similar to those that are or could be provided by someone who is directly employed by an agency. Such parties shall include, but not be limited to: those who are employed by other entities on behalf of an agency and/or for the care and treatment of the person receiving services; consultants; contractors; or volunteers; or
- a family care provider or family care substitute/respite provider; or a party living in the home of the provider.

#### **Administrative appeal process - denial of requested records/documents.**

A requestor denied access to the initial incident/occurrence report or report on actions taken may appeal in writing such denial to the incident records appeals officer designated by the commissioner of OPWDD.

Upon receipt of the appeal, the agency issuing the denial will be notified of the appeal and given an opportunity to submit relevant information to the incident records appeals officer, including the reasons for denial, within 10 business days of the receipt of such appeal. The incident records appeals officer may also request additional information from the requestor as may be necessary to resolve the appeal. Within 10 business days of the receipt of complete information, the incident records appeals officer will make a determination about whether the requested documents should be released. The incident

records appeals officer will issue his or her determination with an explanation of the reasons for the determination to the requestor and the agency. If so directed by the incident records appeals officer, Toomey Residential and Community Services shall provide the requested records and/or documents to the requestor. *Note:* Reports of Obstruction of reports of reportable incidents that are reported to the Justice Center and/or OPWDD are not subject to the notification requirements in this section.

## VIII. Investigation Procedures and Requirements

### **General investigation requirements.**

Any report of a reportable incident or notable occurrence (both serious and minor) shall be thoroughly investigated by Toomey Residential and Community Services 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 Toomey Residential and Community Services of the obligation to investigate. 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.

Toomey Residential and Community Services 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 Toomey Residential and Community Services can reasonably anticipate that the Justice Center or the Central Office of OPWDD is likely to investigate the incident, the actions taken by Toomey Residential and Community Services 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 Toomey Residential and Community Services forgo any of the actions, the Toomey Residential and Community Services shall comply with such direction.

Toomey Residential and Community Services is responsible for monitoring IRMA to ascertain whether the Justice Center, the Central Office of OPWDD, or Toomey Residential and Community Services is responsible for the investigation.

If the Justice Center or the Central Office of OPWDD is responsible for the investigation, Toomey Residential and Community Services shall fully cooperate with the assigned investigator but shall not conduct an independent investigation.

Notwithstanding any other provision in this subdivision, Intermediate Care Facilities shall take steps as needed to comply with federal requirements for the completion of investigations within specified timeframes, including assuming the responsibility for conducting the investigation, if necessary.

Investigations conducted by Toomey Residential and Community Services or the Central Office of OPWDD 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.
- 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.

### **Reclassification of an incident.**

Toomey Residential and Community Services may become aware of additional information concerning an incident that may warrant its reclassification.

- If the incident was classified as a reportable incident by the VPCR, or the additional information may warrant its classification as a reportable incident, a program certified or operated by OPWDD shall report the additional information to the VPCR. At its discretion, the VPCR may reclassify the incident based on the additional information.
- In other cases (e.g. incidents in non-certified programs which are not operated by OPWDD), the Toomey Residential and Community Services shall determine whether the incident is to be reclassified and shall report any reclassification in IRMA.
- In the event that the incident is reclassified, the agency shall make all additional reports and notifications that may be warranted by the reclassification.

### **Investigation reports.**

When Residential and Community Services is responsible for the investigation, the investigation shall be documented. Such documentation shall include an investigative report.

- For all reportable incidents and notable occurrences, investigative reports shall be in the form and format specified by OPWDD.
- For reportable incidents and serious notable occurrences, the full text of the investigative report shall be entered into IRMA. Note: In the event that the Central Office of OPWDD conducts an investigation of an incident or notable occurrence, the Central Office of OPWDD will enter the investigative report into IRMA.
- The investigation shall continue through completion regardless of whether an employee or other custodian who is directly involved leaves employment (or contact with individuals receiving services) before the investigation is complete.
- Toomey Residential and Community Services shall maintain the confidentiality of information regarding the identities of reporters, witnesses, and subjects of reportable incidents and notable occurrences, and limit access to such information to parties who need to know, including, but not limited to, personnel administrators and assigned investigators.

### **Restrictions on situations that may compromise the independence of investigators.**

- 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 Toomey Residential and Community Services. Toomey Residential and Community Services 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.

- 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, the agency shall comply with subparagraph 624.7(d)(7)(ii).

#### **Assignment of investigators for reportable incidents and serious notable occurrences.**

Toomey Residential and Community Services 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.

#### **Notification of subjects.**

For reports of abuse or neglect in programs certified or operated by OPWDD, the agency conducting the investigation shall notify each subject of the report that an investigation is being conducted, unless notifying the subject of the report would impede the investigation. Such notification shall be made in the manner specified by the Justice Center. Such notification or the reason a notification was not made shall be reported to OPWDD in the manner specified by OPWDD.

#### **SCR checks.**

For reports of abuse or neglect in programs certified or operated by OPWDD, the agency conducting the investigation shall submit a request for a check of the Statewide Central Register of Child Abuse and Maltreatment (SCR) concerning each subject of the report. Such request shall be submitted to the Justice Center in the form and manner specified by the Justice Center as soon as the information required to make the request is known or discovered.

As a result of the check, Toomey Residential and Community Services may receive information that one or more indicated reports exist concerning the subject of the report. If this occurs, the agency shall take appropriate steps to gather information contained in the report as specified by the Justice Center. Information obtained pursuant to this paragraph shall be included in the investigation records submitted to OPWDD in accordance with this policy.

#### **Review/investigation by OPWDD and the Justice Center.**

OPWDD and the Justice Center have the right to investigate and/or review any reportable incident. OPWDD also has the right to investigate and/or review any notable occurrence. All relevant records, reports, and/or minutes of meetings at which the incident or occurrence was discussed shall be made

available to reviewers or investigators. Persons receiving services, staff, and any other relevant parties may be interviewed in pursuit of any such investigation or review.

When an incident or occurrence is investigated or reviewed by OPWDD and OPWDD makes recommendations to Toomey Residential and Community Services concerning any matter related to the incident or occurrence (except during survey activities), Toomey Residential and Community Services shall either:

- implement each recommendation in a timely fashion and submit documentation of the implementation to OPWDD; or
- in the event that Toomey Residential and Community Services 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.

In the event that OPWDD or the Justice Center conducts an investigation, the agency may be responsible to conduct some investigatory activities. In these instances, the agency must comply with pertinent requirements.

#### **Findings of reports of abuse or neglect.**

For every report of abuse or neglect, a finding shall be made. Toomey Residential and Community Services shall make the finding or, in the event that the Central Office of OPWDD or the Justice Center conducted the investigation, the Central Office of OPWDD or the Justice Center shall make the finding. A finding shall be based on a preponderance of the evidence and shall indicate whether:

- The report of abuse or neglect is *substantiated* because it is determined that the incident occurred and the subject of the report was responsible or, if no subject can be identified and an incident occurred, that the agency was responsible; or
- The report of abuse or neglect is *unsubstantiated* because it is determined not to have occurred or the subject of the report was not responsible, or because it cannot be determined that the incident occurred or that the subject of the report was responsible.

*Concurrent finding:* In conjunction with the possible findings, a concurrent finding may be made that a systemic problem caused or contributed to the occurrence of the incident.

The Justice Center reviews findings for reports of abuse or neglect in facilities and programs that are certified or operated by OPWDD. When the investigation is conducted by an agency or by OPWDD, findings made by the agency or OPWDD are not considered final until they are reviewed by the Justice Center. The Justice Center may amend findings made by an agency or OPWDD. Findings made by the Justice Center are considered final.

#### **Plans for prevention and remediation for substantiated reports of abuse or neglect when the investigation is conducted by the agency or OPWDD.**

- Within 10 days of the IRC review of a completed investigation, the agency 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 abuse and neglect.

- The plan shall include written endorsement by the CEO or designee.
- The plan shall identify projected implementation dates and specify by title Toomey Residential and Community Services 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.

**Corrections in response to findings and recommendations made by the Justice Center.**

When the Justice Center makes findings concerning reports of abuse and neglect under its jurisdiction and issues a report and/or recommendations to the agency regarding such matters, the Toomey Residential and Community Services shall:

- Make a written response that identifies action taken in response to each correction requested in the report and/or each recommendation made by the Justice Center; and
- Submit the written response to OPWDD in the manner specified by OPWDD, within sixty days after the agency receives a report of findings and/or recommendations from the Justice Center.

**Reporting updates.**

For reportable incidents and serious notable occurrences, Toomey Residential and Community Services shall enter reporting updates into IRMA on at least a monthly basis or more frequently as requested by OPWDD, until closure of the incident or occurrence.

Toomey Residential and Community Services shall complete required fields in IRMA for the reporting update. Among other required information, the reporting update shall include:

- A brief review of additions to the summary of evidence and specific investigatory actions taken since the last update was entered into IRMA, if any; and,
- If there have been no additions to the summary of evidence or investigatory actions taken since the last report, an explanation of why no progress has been made.

If Toomey Residential and Community Services is not responsible for conducting the investigation, then Toomey Residential and Community Services shall complete the required fields to the extent possible given information provided to Toomey Residential and Community Services

If Toomey Residential and Community Services is responsible for conducting the investigation and if the investigation has not been completed within the timeframe specified, Toomey Residential and Community Services shall inform OPWDD of the reason for extending the timeframe of the investigation and shall continue to keep OPWDD informed on at least a monthly basis of the progress of the investigation and other actions taken.

**Timeframe for completion of the investigation.**

When Toomey Residential and Community Services is responsible for the investigation of an incident or notable occurrence, such investigation shall be completed no later than 30 days after the incident or notable occurrence is reported to the Justice Center and/or OPWDD, or, in the case of a minor notable occurrence, no later than 30 days after completion of the written initial occurrence report or entry of

initial information in IRMA. An investigation shall be considered complete upon completion of the investigative report.

Toomey Residential and Community Services may extend the timeframe for completion of a specific investigation beyond 30 days if there is adequate justification to do so. Toomey Residential and Community Services shall document its justification for the extension. Circumstances that may justify an extension include (but are not limited to):

- Whether a related investigation is being conducted by an outside entity (e.g. law enforcement) that has requested that Toomey Residential and Community Services delay necessary investigatory actions, and
- Whether there are delays in obtaining necessary evidence that are beyond the control of Toomey Residential and Community Services (e.g. witness is temporarily unavailable to be interviewed and/or provide a written statement).

#### **Closure of an incident or occurrence.**

*For reportable incidents of abuse and neglect in programs that are not certified or operated by OPWDD and for reportable significant incidents and notable occurrences in all programs and facilities certified, operated, or funded by OPWDD:*

- If Toomey Residential and Community Services conducts the investigation, when the Toomey Residential and Community Services Incident Review Committee (IRC) has ascertained that no further investigation is necessary; or
- If the investigation is conducted by the Central Office of OPWDD, when the Central Office of OPWDD notifies the agency of the results of the investigation; or

*For reportable incidents of abuse and neglect in facilities and programs that are certified or operated by OPWDD:*

- If the agency conducts the investigation, when the Justice Center provides written notice to the agency of the Justice Center's review of the investigation; or
- If the Central Office of OPWDD conducts the investigation, when the Justice Center provides written notice to the agency of the Justice Center's review of the investigation; or
- If the Justice Center conducts the investigation, when the Justice Center provides written notice to the agency that the investigation is completed.

#### **Final reports to the Justice Center.**

Agencies shall submit a final report to OPWDD for all reportable incidents that were accepted by the Justice Center. Final reports must be submitted in the manner, form, and format specified by OPWDD. Final reports must be submitted within 50 days of the Justice Center accepting a report of abuse or neglect, and within 60 days of the Justice Center accepting a report of a significant incident.

Toomey Residential and Community Services 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 instead of Toomey Residential and Community Services, Toomey Residential and Community Services 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, Toomey Residential and Community Services shall provide information as requested by the Justice Center or OPWDD as may be necessary for the completion of the final report.

**Submission of investigation records.**

If Toomey Residential and Community Services conducts the investigation of a report of abuse or neglect that was reported to the Justice Center, Toomey Residential and Community Services shall submit the entirety of the investigation records to OPWDD in the manner and within the timeframe specified by OPWDD.

**Cooperation with the Justice Center.**

In the event that the Justice Center requests additional information from the agency or OPWDD, in accordance with law or regulation, the agency or OPWDD shall provide such requested information in a timely manner.

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

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 shall document the situation and shall report the situation to the agency under whose auspices the event or situation occurred.

*Note:* Mandated reporters (e.g. custodians) are required to make reports to the Justice Center. This means that mandated reporters at the discovering agency must report to the Justice Center upon discovery of a reportable incident that occurred in another program or facility which is certified or operated by OPWDD.

It shall 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 agency policy.

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 shall bring the situation to the attention of OPWDD.

**Record retention.**

Toomey Residential and Community Services shall retain records pertaining to incidents and occurrences.

Records that must be retained include but are not limited to evidence and materials obtained or accessed during the investigative process, copies of all documents generated in accordance with requirements of this policy, and documentation regarding compliance with the requirements of this policy.

Records shall be retained for a *minimum period of seven years* from the date that the incident or occurrence is closed. However, when there is a pending audit or litigation concerning an incident or occurrence, Toomey Residential and Community Services shall retain the pertinent records during the pendency of the audit or litigation.

Records, reports, and documentation shall be retrievable by the person's name and filing number or identification code assigned by Toomey Residential and Community Services. For incidents and occurrences that are reported in IRMA, such information shall be retrievable by the master incident number in IRMA.

When there is an incident or occurrence reported involving more than one person receiving services, from a statistical point of view, the situation shall be considered as one event and shall be recorded as such. Toomey Residential and Community Services shall establish whatever 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.

**Confidentiality of records.**

All records generated in accordance with the requirements of this Part shall 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.

**Retaliation.**

Toomey Residential and Community Services shall not take any retaliatory action against an employee or agent who believes that he or she has reasonable cause to suspect that a person receiving services has been subjected to a reportable incident or notable occurrence, and reports this to the VPCR and/or OPWDD and/or if the employee or agent cooperates with the investigation of a report made to the VPCR or OPWDD.

Effective January 1, 2014, when Toomey Residential and Community Services enters into a new contract or renews a contract for the provision of services that are provided by one or more employees or agents who have regular and substantial physical contact with persons receiving services, the contract shall include a provision concerning retaliation by the contractor. The provision shall require the contractor not to take any retaliatory action against an employee or agent of the contractor when:

- The employee or agent who reports and believes there is reasonable cause to suspect a client has been subjected to a reportable incident or notable occurrence and the employee or agent makes a report to the VPCR and/or OPWDD; and/or,
- If the employee or agent of the contractor cooperates with the investigation of a report to the VPCR or OPWDD.

**Notice of findings involving employees or agents of contractors.**

When an agency receives a written notice of findings from the Justice Center regarding a report of abuse or neglect, and the subject of such notices is an employee or agent of a contractor, the agency shall notify OPWDD of these circumstances within two weeks of such notice.

## **IX. Incident Review Committee (IRC)**

### **Purpose and responsibilities.**

Every agency shall have one or more incident review committees (IRC) to review and monitor reportable incidents and notable occurrences that occur to people receiving services from the agency. The agency's organizational structure and its own policies shall determine the number of committees needed.

The IRC shall review reportable incidents and notable occurrences to:

- Ascertain that reportable incidents and notable occurrences were reported, managed, investigated, and documented consistent with this regulation and agency policy; make written recommendations to appropriate staff and/or CEO;
- Ascertain that necessary and appropriate corrective, preventive, remedial and/or disciplinary action has been taken, to protect persons receiving services from further harm, to safeguard against the recurrence of similar reportable incidents and notable occurrences, and to make written recommendations to the CEO to correct, improve or eliminate inconsistencies;
- Ascertain if further investigation or additional corrective measures (as above) are needed and make written recommendations (as above);
- Identify trends in reportable incidents and notable occurrences, recommend appropriate corrective, remedial (etc. as above); and,
- 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 IRC shall:

- Meet as determined by agency policy, but no less frequently than on a quarterly basis and always within one month of the report of a reportable incident or serious notable occurrence, or sooner if the circumstances so warrant;
- 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;
- Review and monitor all minor notable occurrences that are reported, which may be done by a sub-committee of the IRC or by the individual assignment to members of the IRC, and maintain a record of such incident/occurrence review, recommendations, and/or actions taken in such a manner as to provide for tracking and trending;
- Review and monitor all reportable incidents and/or serious notable occurrences that are reported;
- Review and monitor investigatory procedures, but not routinely perform investigations.
- 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;
- Make written recommendations to the chief executive officer on changes in agency policy or procedures and to improve conditions contributing to the reportable incidents and/or notable occurrences reviewed;
- Forward findings and recommendations to the CEO within two weeks of the meeting;
- Provide documentation that all reports of reportable incidents and serious notable occurrences have been reviewed by the committee and that results and recommendations have been conveyed to appropriate agency executives and others with a need to know;

- Monitor actions taken on any and all recommendations made and advise the CEO 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. This may be done by the full committee or a member of a subcommittee reporting to the full committee;
- Report periodically, but at least annually, to the chief executive officer (CEO), chief agency executives, the governing body and OPWDD concerning the committee's general monitoring functions, general identified trends in reportable incidents 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.

### **IRC and closing incidents.**

For reportable incidents or abuse and neglect in facilities and programs that are certified or operated by OPWDD, an incident shall not be considered closed by an IRC until the agency receives written notification from the Justice Center which specifies that it has accepted an investigation conducted by the agency (or by OPWDD) or, if the Justice Center conducted the investigation, when the Justice Center notifies the agency that the incident is closed. The Justice Center may amend findings made by an agency or OPWDD. Findings made by the Justice Center are considered final.

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

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 requirement, 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 report of abuse or neglect) 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.

### **Organization and membership of the IRC.**

Toomey Residential and Community Services will establish a committee that meets the organizational needs of the agency.

Committee members shall be appointed by the chief executive officer. In the case of a shared committee, each chief executive officer shall appoint committee members and shall approve the shared committee membership arrangement.

Membership of an IRC shall include:

- A member of the governing body;
- At least two professional staff; at least one of the professional staff must be a licensed health care professional (e.g. physician, physician's assistant, nurse practitioner or registered nurse);

- Other staff, including administrative staff, as deemed necessary by the agency to achieve the purposes of the committee;
- At least one direct support professional;
- At least one individual receiving services;
- At least one representative of an advocacy organization (e.g. self-advocacy, family, or other advocacy organizations); and,
- The participation of a psychologist on the committee is recommended.

*Note:* In the event that an agency is unable to obtain the members required, the agency shall document its periodic efforts to obtain the specified members.

### **Membership limitations.**

The chief executive officer of the agency shall not serve as a member of the committee, but may be consulted by the committee in its deliberations.

The administrator of a class or classes of facilities or a group or groups of services may be designated as a member only if the committee is an agency-wide or multi-program committee. If he or she is not a member, an administrator may be consulted by the committee in its deliberations.

### **Case-specific requirements.**

There shall be representation by someone from or with knowledge of the agency's own organizational entity where the event which is under discussion occurred; or by someone familiar with the person(s) involved.

### **Restrictions on review of specific incidents or allegations of abuse.**

Any committee member who recognizes a potential conflict of interest in his or her assignment shall report this information to the committee and recuse himself 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 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.

**Confidentiality training.**

Members of the committee shall be trained in confidentiality laws and regulations and shall comply with section 74 of the public officers law.

**Minutes.**

The chairperson of an incident review committee shall ensure that minutes are kept for all meetings.

For reportable incidents and serious notable occurrences, the portion of the minutes that discuss matters concerning the specific event or situation shall be entered into IRMA 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 (if used), 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 the agency as a result of such recommendations. Full names of all parties involved are to be recorded (not initials).

## **X. Release of Records**

### **Policies and procedures.**

Toomey Residential and Community Services shall have policies and procedures concerning the process for requesting the release of records, including but not limited to identifying appropriate staff who are authorized to receive requests and those who are authorized to release records.

### **Eligible requestors.**

Persons receiving services or who formerly received services, and guardians, parents, spouses, and adult children of such persons, pursuant to paragraph (a)(6) of section 33.16 of the Mental Hygiene Law, are eligible to request the release of records, subject to the following restrictions:

- 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 targeted alleged abuser, regardless of the conclusion.
- If the person receiving services or who formerly received services is a capable adult and objects to the provision of records and/or documents to an otherwise eligible requestor, such requestor is not eligible to receive those records or documents.

### **Records subject to release concerning reports of abuse that occurred *prior* to June 30, 2013.**

Agencies are required to release all records and documents pertaining to allegations and investigations into abuse as defined in applicable OPWDD regulations in effect at the time the allegation occurred under the auspices (see section 624.20 of this Part) of the agency or sponsoring agency to eligible requestors who make a request in accordance with the provisions of this section.

Agencies are required to release records and documents pertaining to allegations of abuse which occurred or were discovered on or after May 5, 2007, regardless of the date of the submission of the written request.

Agencies are required to release records and documents pertaining to allegations of abuse which occurred or were discovered on or after January 1, 2003 but prior to May 5, 2007, if the written request is submitted on or before December 31, 2012.

### **Records subject to release concerning reportable incidents that occurred *on or after* June 30, 2013.**

Agencies are required to release all records and documents pertaining to reportable incidents to eligible requestors who make a request in accordance with the provisions of this section.

### **Procedures.**

Eligible requestors shall submit a written request to the chief executive officer of Toomey Residential and Community Services or staff designated by agency policy/procedures. If the request is made prior to the closure of the incident, the parties specified by agency policy/procedures shall provide the requested records no later than 21 days after the closure of the incident. If the request is made at or

subsequent to the closure of the incident, the agency shall provide the requested records no later than 21 days after the request is made. The written request shall specify the records that are requested.

#### **Redaction of records.**

Prior to the release of records, agencies shall redact the names of employees who are involved in the incident or the investigation or who are interviewed as a part of the investigation, persons receiving services (or who formerly received services), and any information tending to identify such employees or persons. Redaction shall be waived if the employee or person authorizes disclosure, unless redaction of the specific information is necessary because it tends to identify another employee or person who has not authorized disclosure or for another reason.

In addition, if any records which are subject to release identify a particular party as having made a child abuse or maltreatment report to the Statewide Central Register of Child Abuse and Maltreatment (SCR), contacted the SCR, or otherwise cooperated in a child abuse/maltreatment investigation, that name as well as any information tending to identify the party shall be redacted.

#### **Cover letter and dissemination restrictions.**

The release of records shall be accompanied by a cover letter to the recipient which includes the following statement: *"pursuant to section 33.25 of the Mental Hygiene Law, the enclosed records and reports shall not be further disseminated, EXCEPT that you may share the report with:*

- *a health care provider*
- *a behavioral health care provider*
- *law enforcement, if you believe a crime has been committed*
- *your attorney"*

Pursuant to New York State law, the recipient, parties with whom the recipient shared records, or the individual receiving services may use records and documents released in accordance with this section in any legal action or proceeding brought by or on behalf of the individual receiving services.

#### **Documentation.**

The written request for the release of records shall be maintained and the time the request was received shall be documented. A copy of the redacted records that were released shall be maintained and the time the records were provided shall be documented.

#### **Administrative appeal process - denial of requested records/documents.**

A requestor denied access to the records and documents requested pursuant to this section may appeal, in writing, such denial to the incident records appeals officer designated by OPWDD.

Upon receipt of the appeal, Toomey Residential and Community Services will be notified of the appeal and given an opportunity to submit relevant information to the incident records appeals officer, including the reasons for denial, within 10 business days of the receipt of such appeal. The incident records appeals officer may also request additional information from the requestor as may be necessary to resolve the appeal.

Within 10 business days of the receipt of complete information, the incident records appeals officer will make a determination about whether the requested records and/or documents should be released. The incident records appeals officer will issue his or her determination with an explanation of the reasons for the determination to the requestor and the agency. If so directed by the incident records appeals officer, the agency shall provide the requested records and/or documents to the requestor.

Note that records maintained by the agency may also be available under section 496 of the social services law to “other persons named in the report” as defined in section 488 of the social services law.

## **XI. Part 624.20 Glossary**

The Glossary is arranged so that the last word in a title of phrase is the key word to look up, and those words are arranged alphabetically.

- (a) *Abuse or neglect.* Those reportable incidents defined in paragraphs 624.3(b)(1)–(8).
- (b) *Administrator, program.* Someone designated by the governing body and/or the chief executive officer to be responsible and accountable for the daily operation of one or more types services provided by an agency (e.g., ICF program, community residence program, residential habilitation program, respite program, family support program).
- (c) *Adult, capable.* For purposes of this Part, a person 18 years of age or older who is able to understand the nature and implication of an issue. The assessment of capability in relation to each issue as it arises will be made by the person's program planning team (see glossary). Capability, as stipulated by this definition, does not mean legal competency; nor does it necessarily relate to a person's capability to independently handle his or her own financial affairs; nor does it relate to the person's capacity to understand appropriate disclosures regarding proposed professional medical treatment. Whenever there is doubt on the part of any other party interested in the welfare of the person as to that person's ability to make decisions, as ascertained by the program planning team or others called upon by and agency, a determination of capability for a specific issue or issues may be made by a Capability Review board (see. glossary) designated by the commissioner except that in an ICF/MR facility the requirements of section 681.13 of this Title may apply. A capable adult person cannot override the authority granted a guardian pursuant to article 81 of the Mental Hygiene Law or of a conservator or a committee; or the authority granted a guardian in accordance with the Surrogate Court Procedure Act.
- (d) *Advocate.* As used in this Part, someone who has volunteered to help a person apply for HCBS waiver services who gives advice and support, who helps the person make informed choices, and who acts on behalf of the person when that person is unable to do so by himself or herself. While an advocate plays an active role in promoting self-advocacy and in assisting with service planning, implementation, and monitoring, he or she has no legal authority over a person's affairs unless designated as the legal guardian.
- (e) *Agency.* The operator of a facility, program, or service operated, certified, authorized, or funded through contract by OPWDD. In the case of State-operated facilities, the Developmental Disabilities State Operations Office (DDSOO) is considered to be the agency. Family care providers are not considered to be an agency (also see agency, sponsoring). The term “agency” as used in this Part includes sponsoring agencies.
- (f) *Agency, sponsoring.* An oversight entity of one or more OPWDD certified family care homes. In the case of family care homes operated under state sponsorship, the DDSOO is considered to be the sponsoring agency.
- (g) *Agency, State.* A New York State governmental unit created for the management/ delivery of services to the citizens of the State.
- (h) *Allegation (of abuse or neglect).* For purposes of this Part, the implication that abuse or neglect of a person may have occurred, based upon the report of a witness, upon a person's own account, or upon physical evidence of probable abuse or neglect.

- (i) *Application, Incident Report and Management (IRMA)*. A secure web-based statewide database for incident reporting that is used by providers in the OPWDD system.
- (j) *Auspices, under the*. For the purposes of this Part and Part 625 of this Title, an event or situation in which the agency or family care provider 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 the agency or family care provider.
  - (1) Events or situations that are under the auspices of the agency or family care provider include but are not limited to:
    - (i) An event or situation in which agency personnel (staff, interns, contractors, consultants, and/or volunteers) or a family care provider (or respite/substitute provider) 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 the agency or family care home, even in the absence of agency personnel or the family care provider.
    - (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 this Title.
    - (iv) Notwithstanding any other requirement in this subdivision, the death of an individual receiving services who lives in a residential facility operated or certified by OPWDD, including a family care home, is always under the auspices of the agency. The death is also under the auspices of the agency 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 this Part, any event that directly involves or may have involved agency personnel or a family care provider (or respite/substitute provider) or someone who lives in the home of the family care provider.
  - (2) Events or situations that are not under the auspices of an agency include:
    - (i) Any event or situation that directly involves or may have involved agency personnel or a family care provider (or respite/substitute provider) 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 (other than a custodian or another individual receiving services), whether or not in the presence of agency personnel or a family care provider or 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 agency personnel or a family care provider.

- (iv) Any report of neglect that is based on conditions in a private home (excluding a family care home).
- (v) The death of an individual who received OPWDD operated, certified, or funded services, except deaths that occurred under the auspices of an agency as specified in paragraph (1) of this subdivision.
- (k) *Board, capability review.* Those designated by OPWDD to review the ability of a person to consent to a particular situation when there is a dispute as to that person's ability. Capability review board services are not available in Intermediate Care Facilities.
- (l) *Body, governing.* The over-all policy-making authority, whether an individual or a group, that exercises general direction over the affairs of an agency and establishes policies concerning its operation for the welfare of the persons it serves. In state-operated services, the governing body shall be the Central Office of OPWDD. For purposes of this Part, a family care home does not have a governing body.
- (m) *Contact, sexual.* As specified in Penal Law §130.00(3), the touching or fondling of the sexual or other intimate parts of a person not married to the actor for the purpose of gratifying the sexual desire of either party, whether directly or through clothing. It also includes causing a person to touch anyone else for the purpose of arousing or gratifying personal sexual desires.
- (n) *Correspondent.* Someone (not on the staff of the facility) who assists a person in obtaining necessary services, who participates in the person's program planning process, and who receives notification of certain significant events in the life of the person. The fact that a correspondent is providing advocacy for a person as a correspondent does not endow that individual with any legal authority over a person's affairs.
- (o) *Crime.* An act that is forbidden by law that makes the offender liable to punishment pursuant to that law. In New York State, the Penal Law defines a crime as a misdemeanor or a felony, but does not include a traffic infraction.
- (p) *Custodian.* A party that meets one of the following criteria:
  - (1) a director, operator, employee, or volunteer of an agency; or
  - (2) a consultant or an employee or volunteer of a corporation, partnership, organization, or governmental entity that provides goods or services to an agency pursuant to contract or other arrangement that permits such party to have regular and substantial contact with individuals receiving services; or
  - (3) a family care provider; or
  - (4) a family care respite/substitute provider.
- (q) *Disability, developmental.* A disability of a person which:
  - (1)

- (i) is attributable to mental retardation, cerebral palsy, epilepsy, neurological impairment, familial dysautonomia or autism;
  - (ii) is attributable to any other condition of a person found to be closely related to mental retardation because such condition results in similar impairment of general intellectual functioning or adaptive behavior to that of persons with mental retardation or requires treatment and services similar to those required for such persons;
  - (iii) is attributable to dyslexia resulting from a disability described in subparagraph (i) or (ii) of this paragraph;
- (2) originates before such person attains age 22;
- (3) has continued or can be expected to continue indefinitely; and
- (4) constitutes a substantial handicap to such person's ability to function normally in society.
- (r) *Facility*. Unless otherwise defined or modified, facility means a developmental center or any other site certified by OPWDD in which either residential or non-residential services are provided to persons with developmental disabilities (e.g., community residence including an individualized residential alternative (IRA), intermediate care facility (ICF/DD), day treatment, workshop, clinic, family care home, or a day habilitation site).
- (s) *Injury, physical and "impairment of physical condition."* Any confirmed harm, hurt, or damage resulting in a significant worsening or diminution of an individual's physical condition.
- (t) *Intentionally*. This term shall have the same meaning as provided in subdivision one of section 15.05 of the penal law which states: "A person acts intentionally with respect to a result or to conduct described by a statute defining an offense when his conscious objective is to cause such result or to engage in such conduct."
- (u) *Investigate/investigation*. That systematic process whereby information about the circumstances surrounding an event/situation are examined and scrutinized, whether by a chief executive officer, designated staff, or a trained investigator (see glossary). The intensity of any investigation is decided by the event/situation under study.
- (v) *Investigator*. That party or parties, designated by the chief executive officer (or designee), by the Central Office of OPWDD, or by the Justice Center, responsible for collecting information to establish the facts relative to an event/situation, whether immediately following or subsequent to that event/situation. Investigators may be required to have training as specified by OPWDD or the Justice Center.
- (w) *Justice Center for the Protection of People with Special Needs (Justice Center)*. An entity established by Article 20 of the Executive Law for the protection of people who are vulnerable because of their reliance on professional caregivers to help them overcome physical, cognitive, and other challenges. The Justice Center contains the Vulnerable Persons' Central Register (VPCR) as established by Article 11 of the Social Services Law and receives requests for criminal history record checks pursuant to section 16.33 of the Mental Hygiene Law.

- (x) *Office, Developmental Disabilities State Operations (DDSOO)*. The local administrative unit of OPWDD responsible for the provision of state-operated services within a particular geographic area.
- (y) *Officer, Chief Executive*. Someone (by whatever name or title known) designated by the governing body (see glossary) with overall and ultimate responsibility for the operation of one or more classes of facility, for the delivery of other services to persons with developmental disabilities, and with control over any and all equipment used in the care and treatment of such persons; or a designee with specific responsibilities as specified in agency policy/procedure. In a DDSOO, this party is referred to as the Director.
- (z) *Person/persons*. For purposes of this Part, a child or adult with a developmental disability, who has been or is receiving services that are operated, certified, sponsored, or funded by OPWDD.
- (aa) *Procedures, formal search*. A systematic process involving employees with specific responsibilities (e.g., security personnel), law enforcement agencies, and any others designated by agency policy and which is initiated for the purpose of locating a person who has not been found in response to an informal search.
- (ab) *Provider, family care*. One or more adults age 21 or over to whom an operating certificate has been issued by OPWDD to operate a family care home. A family care provider is an independent contractor.
- (ac) *Recklessly*. This term shall have the same meaning as provided in subdivision three of section 15.05 of the penal law, which states: "A person acts recklessly with respect to a result or to a circumstance described by a statute defining an offense when he is aware of and consciously disregards a substantial and unjustifiable risk that such result will occur or that such circumstance exists. The risk must be of such nature and degree that disregard thereof constitutes a gross deviation from the standard of conduct that a reasonable person would observe in the situation. A person who creates such a risk but is unaware thereof solely by reason of voluntary intoxication also acts recklessly with respect thereto."
- (ad) *Report, investigative*. A comprehensive written record of a completed investigation of an event or situation. The purpose of this report is to formalize an investigator's methodology, findings, conclusions, and recommendations upon the completion of an investigation.
- (ae) *Report, written initial incident/occurrence*. The document that records initial information about a reportable incident or notable occurrence, in conformance with this Part.
- (af) *Service, Mental Hygiene Legal (MHLS)*. A service of the appellate division of the State Supreme Court established pursuant to article 47 of the Mental Hygiene Law. (Formerly, mental health information service - MHIS.)
- (ag) *Services, plan of*. An individualized record system, by whatever name known, which documents the process of developing, implementing, coordinating, reviewing, and modifying an individual's total plan of care, including, but not limited to, health care, clinical, and habilitation services (as applicable) to address the individual's needs.
- (ah) *Subject (of a report)*. A custodian who is reported to the VPCR for the alleged abuse or neglect of a person receiving services.

- (ai) *Substantiated*. A finding concerning a report of abuse or neglect based on a preponderance of the evidence. The report of abuse or neglect is substantiated when it is determined that the incident occurred and the subject of the report was responsible or, if no subject can be identified and an incident occurred, that, the facility or provider agency was responsible.
- (aj) *Treatment, requiring medical or dental*. That situation in which a person who, by virtue of his or her condition as a result of a minor or serious notable occurrence, must see a physician, dentist, physician's assistant, or nurse practitioner to have the condition controlled and/or attended to with more than first-aid procedures. While individual agency policy/procedure may direct that a person who is in anyway injured or has suffered any ill effects is to see a medical professional even though first-aid has adequately addressed the situation, this does not always constitute requiring medical or dental treatment in terms of defining a notable occurrence. If a person is retained in a hospital overnight for observation, this would be a situation that required medical treatment, and be reported as a serious notable occurrence.
- (ak) *Unsubstantiated*. A finding concerning a report of abuse or neglect based on a preponderance of the evidence. The report of abuse or neglect is unsubstantiated because it is determined not to have occurred or the subject of the report was not responsible, or because it cannot be determined that the incident occurred or that the subject of the report was responsible.
- (al) *Vulnerable Persons' Central Register (VPCR)*. An entity established in the Justice Center by section 492 of the Social Services Law. The VPCR shall:
- (1) receive reports of reportable incidents involving persons receiving services in programs operated or certified by OPWDD (and specified programs subject to the oversight of other state agencies);
  - (2) as warranted, refer reports alleging crimes to appropriate law enforcement authorities;
  - (3) notify appropriate parties and officials of received and accepted reports; and
  - (4) maintain an electronic database of each report and the finding associated with each report.

## **XII. Identifying Part 625 Events/Situations**

### EVENTS AND SITUATIONS THAT ARE NOT UNDER THE AUSPICES OF AN AGENCY.

This Part is applicable to all facilities and programs that are operated, certified, or funded by OPWDD for the provision of services to individuals with developmental disabilities.

Requirements concerning events and situations that are not under the auspices of an agency are found in this Part. (Note that requirements concerning events and situations that are under the auspices of an agency are in Part 624).

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

Intermediate Care Facilities must also comply with the requirements of 42 CFR Part 483. Events and situations involving ICF residents that meet the definitions of abuse and other violations under the federal regulation, but do not occur under the auspices of the ICF, must be reported and thoroughly investigated in accordance with federal requirements in 42 CFR 483 that are more stringent than the requirements of this Part.

### **Definitions.**

- 1) **Auspices, under the.** For the purposes of Part 625 and Part 624 of this Title, an event or situation in which the agency or family care provider 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 the agency or family care provider.
  - (i) Events or situations that ARE under the auspices of the agency or family care provider include but are not limited to:
    - a) An event or situation in which agency personnel (staff, interns, contractors, consultants, and/or volunteers) or a family care provider (or respite/substitute provider) are, or should have been, physically present and providing services at that point in time.
    - b) Any situation involving physical conditions at the site provided by the agency or family care home, even in the absence of agency personnel or the family care provider.
    - c) 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.
    - d) Notwithstanding any other requirement in this subdivision, the death of an individual receiving services who lives in a residential facility operated or certified by OPWDD, including a family care home, is always under the auspices of the agency. The death is also under the auspices of the agency 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.)
    - e) Related to reportable incidents and notable occurrences as defined in sections 624.3 and 624.4 of this Title, any event that directly involves or may have involved agency personnel or a family care provider (or respite/substitute provider) or someone who lives in the home of the family care provider.

- (ii) Events or situations that ARE NOT under the auspices of an agency include:
- a) Any event or situation that directly involves or may have involved agency personnel or a family care provider (or respite/substitute provider) 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).
  - b) Any event or situation that exclusively involves the family, friends, employers, or co-workers of an individual receiving services (other than a custodian or another individual receiving services), whether or not in the presence of agency personnel or a family care provider or at a certified site.
  - c) 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 agency personnel or a family care provider.
  - d) Any report of neglect that is based on conditions in a private home (excluding a family care home).
  - e) The death of an individual who received OPWDD operated, certified, or funded services, except deaths that occurred under the auspices of an agency.

- 2) **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.
- 3) **Sexual abuse.** Non-consensual sexual contact of any kind, including but not limited to, forcing sexual contact or forcing sex with a third party.
- 4) **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.
- 5) **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.
- 6) **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.
- 7) **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.
- 8) **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.
- 9) **Death.** The end of life, expected or unexpected, regardless of cause.

### **Agency involvement in events or situations that are not under the auspices of an agency.**

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

If the event or situation meets one of the definitions in Part 624 (reportable incidents and notable occurrences) and occurred under the auspices of another agency subject to the requirements of Part 624 of this Title:

- The agency is required to document the event or situation and report the situation to the agency under whose auspices the event or situation occurred.
- Note that mandated reporters (e.g. custodians) are required to make reports to the Vulnerable Persons' Central Register (VPCR). This means that mandated reporters at the discovering agency must report to the VPCR upon discovery of a reportable incident that occurred in another program or facility that is certified or operated by OPWDD.
- If the event or situation meets one of the definitions in sections 624.3 or 624.4 and occurred in a facility or service setting subject to the regulatory oversight of another State Agency (e.g. school, hospital), the agency shall document the event or situation and shall report the situation to the management of the facility or service setting.
- The agency shall intervene if it has reason to believe (e.g. a report or complaint is made to the agency, 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 Part 625.
- Requirements concerning agency involvement in deaths that are not under the auspices of an agency are in Part 625.

The agency 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:

- 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);
- Offering to make referrals to appropriate service providers, clinicians, State agencies, or any other appropriate parties;
- Interviewing the involved individual and/or witnesses;
- Assessing and monitoring the individual;
- Reviewing records and other relevant documentation; and
- Educating the individual about his or her choices and options regarding the matter.

The agency shall intervene as it deems necessary and appropriate 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:

- The individual resides in a residence certified or operated by OPWDD (or a family care home)
- The individual receives day program services certified or operated by OPWDD;
- The individual receives Medicaid Service Coordination (MSC) or Plan of Care Support Services (PCSS) authorized by OPWDD, and/or

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

The agency 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:

- The individual is only receiving family support services (FSS), individual support services (ISS), or Article 16 clinic services; and/or
- The individual is not available to the agency or sponsoring agency; and/or
- The individual is in need of protective services that the agency cannot provide.

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.

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. 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 the agency 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.

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 the agency (625.4).**

*Reporting to OPWDD:* The agency shall report events or situations in which actions were taken by the agency in accordance with the requirements of Part 625 as follows:

- 1) Submit an initial report about the event or situation in the OPWDD Incident Report and Management Application (IRMA).
- 2) 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 the agency, including any initial actions taken to protect the involved individual.
- 3) 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 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.

*Review/investigation by OPWDD:* OPWDD has the right to investigate or review any event or situation regardless of the source of the information. The agency 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.

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

- Implement each recommendation in a timely fashion and submit documentation of the implementation to OPWDD; or
- In the event that the agency 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 the agency (625.5).**

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 any agency, shall be reported to the Justice Center as follows:

- 1) The initial report shall be submitted by the agency'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.)

Note: The requirements of this subdivision do not apply to the death of an individual who received only OPWDD funded services provided by Toomey Residential and Community Services, rather than services that are operated or certified by OPWDD, to the death of an individual who resided in an OPWDD certified or operated residential program or when the death occurred under the auspices of an agency.

**All deaths that are reported to the Justice Center shall also be reported to OPWDD.**

A death that occurred under the auspices of a provider agency shall be reported as a serious notable occurrence in accordance with Part 624 of this Title. A death that did not occur under the auspices of any agency shall be reported in accordance with Part 625.

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 any agency, 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) The agency 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) The agency 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.

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 to the Justice Center and/or OPWDD. The agency responsible for reporting in accordance with this paragraph 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 the agency that provided the greater duration on a regular basis.
- (ii) MSC or PCSS (only OPWDD operated services report to the Justice Center);
- (iii) HCBS Waiver services (only OPWDD operated services report to the Justice Center);
- (iv) Care at Home Waiver services (only OPWDD operated services report to the Justice Center);
- (v) Article 16 clinic services;
- (vi) FSS or ISS services (only OPWDD operated services report to the Justice Center);
- (vii) Any other service operated or funded by OPWDD.

**Investigations into deaths that did not occur under the auspices of an agency.**

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 the agency. The agency 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.

OPWDD has the right to investigate or review, or to request a provider agency to investigate, the death of any individual, even if the death did not occur under the auspices of the agency. The agency 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.

If the Justice Center or OPWDD is responsible for the investigation, the agency shall fully cooperate with the assigned investigator.

### **XIII. APPENDIX**

- (1) Learning About Incidents (OPWDD Brochure)
- (2) Section 488: Definitions (from NYS Social Services Law, effective June 30,2013)
- (3) New OPWDD Categories/Classifications of Incidents (Part 624), effective June 30, 2013
- (4) Part 625 Events/Situation Not Under the Auspices of an Agency, effective June 30, 2013
- (5) Part 624 OPWDD and JC Death Reporting Requirements, effective June 30, 2013
- (6) Form OPWDD 147, revised 6/30/13
- (7) Instructions for Completing Form OPWDD 147, revised 8/2013
- (8) Form OPWDD 148 Report on Actions Taken in Response to an Incident, 6/2012
- (9) Form OPWDD 149: Investigative Report Format, revised 7/18/13
- (10) Form OPWDD 149: Investigative Report Format-Completions Instructions, revised 6/30/13
- (11) Form OPWDD 150, revised 8/2013 (for Part 625 Events/Situations)
- (12) Instructions for Completing Form OPWDD 150, 8/20/13
- (13) Submission Form 158 for Investigative Record of Abuse/Neglect, 12/27/13
- (14) Decision Matrix for Reporting to Law Enforcement, 4/19/12