Catholic Charities Disabilities Services	
Agency Standard and Procedure	
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Regulations	14 NYCRR Parts 624, 625
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Attachments	#1 Incident Definitions #2 Parent/Guardian/Advocate Notification Script #3 Investigation Guide
Approved by: Paula Warika, Executive Director	Paula Warika

Standard:
Catholic Charities Disabilities Services will have an incident management system that meets all regulatory requirements and reflects best practices.

Specifically, once an incident has been discovered, staff will respond to the situation in a timely manner, and provide all necessary protective actions to ensure that the individual or individuals are safe. The incident will be investigated to the extent necessary to determine the facts and identify opportunities for improvement. The Incident Review Committee will sanction the findings of the investigation as well as both ensure that all needed changes are made and that incidents are analyzed to identify any systemic changes that need to be made. All incidents will be reported and, where required, investigated in compliance with the requirements of 14 NYCRR Parts 624 and 625 and such other administrative directives as may be issued by the Office for People with Developmental Disabilities and the Justice Center for the Protection of People with Special Needs.

Definitions [1]
The agency will utilize those definitions contained in statutes, regulations and administrative guidelines governing the operation of programs and services certified or funded by the Office for People with Developmental Disabilities, (OPWDD), the Justice Center for the Protection of People with Special Needs (Justice Center), the Office of Children and Family Services (OCFS), and the Department of Health (DOH) defining incidents which are to be reported and, where required, investigated by CCDS.
Additionally, the agency defines the following situations as "Agency Incidents:"[2]

1. **Injury**: any suspected or confirmed harm, hurt or damage to an individual, caused by an act of that individual or another whether or not by accident, and requiring no more than first aid treatment;
2. **Medication Error**: any preventable event that may cause or lead to inappropriate medication use or harm to a person, including a dose of medication that deviates from the physician's order/prescription. Except for errors of omission, the medication dose must actually reach an individual. An error that is detected and corrected prior to administration to the individual is not

[1] Please see Attachment #1

a medication error. Agency medication errors will consist of both "five rights" medication errors, and "procedural" or documentation medication errors ("six rights" include right documentation);

3. **Sensitive Situation**: any situation involving an individual which may be of a delicate nature to the agency, which is reported to administration to ensure awareness of the circumstances.

Immediate Response to All Incidents

1. Staff discovering any incident are to take any and all steps necessary to ensure the safety of the individual or individuals supported involved.

2. The Residential and Individualized Community Services Departments will maintain an on-call roster of administrators to provide telephone consultation to staff at all times.

3. The Quality Assurance Department (QA) will maintain an on—call roster of staff to provide telephone consultation to the Administration on Call (AOC) at all times.

4. The Quality Assurance Department will maintain a roster of available trained investigators.

5. If staff discover a situation that may be child abuse, which is not otherwise required to be reported to the Justice Center, state law requires that the staff member discovering the possible child abuse call the child abuse hotline. (See also Standard: Reporting of Allegations of Child Abuse)

Immediate Response to Incidents Involving Individuals Receiving Individualized Community Services

1. If Individualized Community Services staff discover an incident, they are to see to the individual's needs if necessary and complete an electronic events report General Event Report (GER). Staff are to follow departmental procedures regarding providing support to the individual as well as regarding contact with the Individualized Community Services on-call.

2. If staff discover a situation that may be child abuse in any setting other than in a State operated or certified program, State law requires that the staff member discovering the possible child abuse call the child abuse hotline. Abuse of an individual of any age in a State operated or certified setting is to be reported as required in # 6, and to the Justice Center. See also Standard: Reporting of Allegations of Child Abuse.

3. Once notified, the AOC takes immediate steps to:
    a. Ensure the well-being of the individual by seeing to their safety and obtaining whatever medical attention or examination may be warranted;
    b. If necessary, separate the subject from the individual(s) by placing the subject on administrative leave or by reassigning the subject (see "Standard for Administrative Leave During Investigations" for instructions). If the incident is an allegation of physical or sexual abuse involving an employee, it is expected that the staff person will be placed on administrative leave. Law Enforcement will also be notified. Any deviation of this expectation will require the approval of the executive director or designee;
    c. Notify the QA Administrator-On-Call to both inform QA of the incident and to consult with QA on other possible appropriate actions;

[2]There are other events which require the completion of a GER

d. If the incident meets the definition of a Reportable Incident or Notable Occurrence make all required internal notifications including to the executive director, associate executive director(s), appropriate program directors (see also paragraph 5 under 'investigation" below).

4. The AOC will document his/her actions regarding the incident on the electronic events report (GER). Depending upon the seriousness of the incident, GERs are to be reviewed by appropriate staff including supervisors, managers, associate directors, directors, quality assurance, consultant, associate executive directors and executive director. Authority to review GERs is determined by the agency. In cases of allegations of abuse or neglect, ability to review the GER will be determined by the Executive Director or designee.

5. All Reportable Incidents and Notable Occurrences will be investigated. A plan to commence the investigation will be determined by the QA Administrator On-Call in consultation with the executive director and/or the Program AOC. If necessary, the investigator will be on site within 24 hours.

6. For Reportable Incidents and Notable Occurrences, the AOC or designee will ensure that the parent, guardian, spouse or adult child, or, if none, the advocate or the individual, as well as the care manager, is informed of the incident within 24 hours. Staff will document on the electronic events report (GER) that all requirements of notifications are met (e.g. offer of a meeting with the ED or designee, offer to provide information on the status and/or findings of the investigation, etc.).

Immediate Response to Incidents Involving Individuals Receiving Residential Services

1. If residential staff discover an incident involving a medication error, they are to see to the individual's needs, inform their supervisor, contact nursing on call, and complete an electronic events report (GER). The nurse will determine what follow-up action, if any, is necessary (Please see "Standard: Medication Errors" for further information).

2. If residential staff discover an incident involving an injury, they are to see to the individual's needs, inform their supervisor, and contact nursing on call and the AOC. The nurse will determine what treatment, if any, is required and whether or not a GER needs to be completed. If the nurse or AOC determines that a GER is necessary, the staff reporting the injury will complete a T Log, which describes both the injury and the nurse's instructions and complete the required GER. If the nurse or AOC determines that a GER is not necessary, the staff reporting the injury will complete a T Log which describes both the injury and the nurse's instructions.

3. There will be certain instances in which a photograph will be helpful in documenting an individual's initial injury and changes in the appearance of the injury over time, particularly in the case of injuries of unknown origin. If, upon review of a GER, T-log or other report of an injury, the Executive Director, Associate Executive Director, Director of Quality Assurance, Quality Assurance Specialists, RN, the Director of Residential Services or AOC believe that a photograph of an injury is necessary, they may direct that a photograph be taken. Photographs may only be taken on an agency owned camera or cell phone, and may only be taken by one of the above named individuals, a nurse, program manager, site supervisor or shift supervisor. Photographs will be taken in accordance with the instructions given by the RN or administrator

directing that the photograph be taken, taken in a way that safeguards the privacy and dignity of the individual involved, and, if possible, taken only with the permission of the individual involved.

4. If residential staff discover an incident involving a sensitive situation, they are to see to the individual's needs, notify their supervisor (or the Residential AOC if their supervisor is not available) and complete a GER.

5. If residential staff discover an incident that could be defined as a Reportable Incident or a Notable Occurrence (see Incident Definitions attached to this Standard), they are to see to the individual's needs, contact nursing on call (if necessary), inform their supervisor, contact the residential AOC and complete a GER.

6. If residential staff discover an incident that could be defined as a Reportable Incident or a Notable Occurrence (see Incident Definitions attached to this Standard), they are also to report the incident to the Justice Center. Such a report must be made by any staff who have direct knowledge of the incident, as well as the AOC, unless a staff member is aware that the incident was already reported to the Justice Center and the staff member knows that he or she was named in the report as a person having knowledge of the incident. Staff may consult with the AOC and/or QA prior to making the report to the Justice Center, but are not required to do so.

7. Once notified, the AOC gathers sufficient information to determine whether or not the incident can be classified as a Reportable Incident or a Notable Occurrence. The AOC takes immediate steps to:
    a. Ensure the well-being of the individual by seeing to their safety and obtaining whatever medical attention or examination may be warranted;
    b. Ensure that the needs of all other individuals who may be present are met;
    c. If necessary, separate the subject from the individual(s) by placing the subject on administrative leave or by reassigning the subject (see Standard for "Administrative Leave During Investigations" for instructions). If the incident is an allegation of physical or sexual abuse involving an employee, it is expected that the staff person will be placed on administrative leave. Law Enforcement will also be notified. Any deviation of this expectation will require the approval of the Executive Director or designee;
    d. If necessary, ensure that evidence is preserved to the extent possible by ordering the scene of the incident off limits;
    e. Notify QA staff on—call to both inform QA of the incident and to consult with QA on other appropriate actions;
    f. If a Reportable Incident or Notable Occurrence, make all required internal notifications including to the Executive Director (or designee), and appropriate program directors.

8. After consulting with the appropriate internal parties, the AOC makes an additional assessment of the situation and makes any needed adjustments. Depending upon the circumstances of the incident, this additional assessment may include the on-site presence of the AOC.

9. The AOC will document his/her actions regarding the incident on the GER. Depending upon the seriousness of the incident, GERs are to be reviewed by appropriate staff including supervisors, managers, associate directors, directors, quality assurance, consultant, associate executive director and executive director. Authority to review GERS is determined by the agency. In cases

of allegations of abuse or neglect, ability to review the GER will be determined by the Executive Director or designee.

10. All Reportable Incidents and Notable Occurrences will be investigated. A plan to commence the investigation will be determined by the QA on call in consultation with the Executive Director and/or the AOC. If necessary, the investigator will be on site within 24 hours.

11. For Reportable Incidents and Notable Occurrences, the AOC or designee will ensure that the parent, guardian, spouse or adult child or, if none, the advocate or the individual (see Attachment #2, Notification Script), as well as the care manager, is informed of the incident within 24 hours. Staff will document on the GER that all requirements of notifications are met (e.g. offer of a meeting with the ED or designee, offer to provide information on the status and/or findings of the investigation, etc.).

Investigation

1. Once the QA Administrator on-call has confirmed that the incident requires investigation, an investigation will be commenced immediately. All investigations will be conducted in accordance with the requirements of 14 NYCRR Part 624 and any applicable administrative directives which may be issued by OPWDD and the Justice Center.

2. For all Reportable Incidents and Notable Occurrences (except Injury), the investigator will contact the OPWDD Incident Management Unit (IMU) via phone immediately upon learning of the incident. The investigator or designee will also be responsible for immediately notifying law enforcement if it appears that a crime may have been committed against an individual.

3. The investigation will be supervised by the Director of Quality Assurance or designee. All investigations will follow a work plan which will determine the questions to be answered by the investigation, the sources of evidence available, and the process and time frame for obtaining required evidence.

4. All investigations will be documented through a series of written reports. An initial report, documenting steps taken to safeguard the individual, will be completed by the close of business the next business day after the initiation of the investigation. Additional updated reports will be written as determined through the supervision of the investigation.

5. The Director of Quality Assurance will be responsible to ensure that all internal and external notifications as required by law, regulation, and policy are completed. The Department will maintain an up-to-date "Investigation Guide" which will direct investigators as to notification protocols.[3]

6. It is expected that investigations will be completed and a report readied for review by the Incident Review Committee within 30 calendar days from the date of discovery.

7. Investigation reports will follow a standard format as required by OPWDD which includes identifying information regarding the individual(s) involved, brief clinical information, a statement describing the incident, the safeguards employed to protect the individual, findings, conclusion, and recommendations.

8. All reports will be submitted to the Director of Quality Assurance or designee for review and approval.

9. Once approved, reports will be distributed to the Executive Director, members of the Incident Review Committee, and the appropriate program director. Initial actions taken in response to the proposed recommendations will be initiated if possible.

Incident Review Committee

1. The agency will establish an Incident Review Committee (IRC) which will have four responsibilities: to review and accept investigation reports, confirm or make recommendations, ensure that recommendations are met, and that incidents are periodically analyzed to identify trends and/or systemic issues.

2. The membership of the IRC may include as ex-officio members the Associate Executive Director, Director of Residential Services, Director of Individualized Community Services. The Executive Director or designee will additionally appoint to the committee a member of the governing body, a direct support professional, professional staff which may include an RN, BIS, QIDP, PT or other professional staff, and a representative of advocacy organizations. At least one of the professional staff will be a licensed health care practitioner (e.g. physician, physician's assistant, nurse practitioner, or registered nurse). The executive director may appoint additional members as she or he sees fit. The executive director will designate one of the members of the committee as chair. The Quality Assurance Department will provide staff support to the committee. The IRC Chair will call upon additional staff to assist the committee if their particular expertise is needed.

3. The IRC will meet monthly or as needed in compliance with the requirements of 14 NYCRR Parts 624 and 625. A quorum will consist of the presence of at least one-half of the membership. All decisions will be made through a simple majority vote. Any member will recuse him or herself if they were the subject of the investigation, the direct supervisor of a subject of a matter before the IRC, or other circumstance in which they or the committee chair identify a potential conflict of interest.

4. The written investigation report will be shared with the membership prior to the meeting. It is expected that the membership will have read the report prior to the meeting. The assigned investigator will present a summary of the report to the IRC which will either accept the report as written or return it to the investigator for additional work. The IRC will consider the thoroughness, findings, conclusions and recommendations of the investigation.

5. All open cases, including cases pending before the Justice Center, will be examined by the IRC at each meeting. The IRC will also evaluate the status of recommendations made. It will be the responsibility of the appropriate program director or designee to provide the IRC with documentation or a progress report of work to complete any recommendations prior to the IRC meeting.

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[3]Please see Attachment #2

6. A database will be kept for all incidents to assist with trend analysis. This report will be presented no less than annually, or as requested by the Executive Director, a report will be prepared by the Quality Assurance Department for the IRC, to assist with their incident analysis. The report will be shared with the membership prior to the meeting.

7. Minutes of all meetings will be kept by Quality Assurance and will be distributed to the IRC, Executive Director and Associate Executive Director within three weeks of the meeting. The IRC will be asked to confirm the minutes as accurate. Minutes specific to an incident investigation will be added to the investigation file. Minutes for investigations of reportable and notable occurrences will be entered to IRMA and, if required, the entire investigation will be sent to the Justice Center through OPWDD.

8. All investigations will remain "open" until the IRC has determined that there is sufficient evidence to determine that the recommendations of the investigation have either been realized or the process to initiate corrective action has begun. Abuse or neglect investigations which are delegated to CCDS by the Justice Center for investigation will remain "open" in the OPWDD electronic incident management system until the Justice Center confirms the CCDS determination and all recommendations are completed.

9. For all incidents, the IRC minutes will be sent to CCDA Corporate Compliance.

10. Additionally, for allegations of abuse or neglect, the IRC Minutes will be sent to the MHLS and to CCDA Corporate Compliance.

Events/Situations Not Under the Auspices of the Agency

Events and Situations which are "Not Under the Auspices of the Agency " as defined by regulation will be reported to OPWDD by the Quality Assurance Department in accordance with the requirements of 14 NYCRR Part 625.

14 CRR-NY 624.3

624.3 Reportable incidents, defined.

(a) Reportable incidents are events or situations that meet the definitions in subdivision (b) of this section and occur under the auspices (see glossary, section 624.20 of this Part) of an agency.

(b) Definitions of reportable incidents.

(1) *Physical abuse.* Conduct by a custodian (see glossary, section 624.20 of this Part) intentionally (see glossary, section 624.20 of this Part) or recklessly (see glossary, section 624.20 of this Part) causing, by physical contact, physical injury (see glossary, section 624.20 of this Part) 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 is not limited to: slapping, hitting, kicking, biting, choking, smothering, shoving, dragging, throwing, punching, shaking, burning, cutting, or the use of corporal punishment. Physical abuse does not include reasonable emergency interventions necessary to protect the safety of any party.

(2) *Sexual abuse.*
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 article 230 or 263 of the Penal Law. For purposes of this paragraph only, a person with a developmental disability who is or was receiving services and is also an employee or volunteer of an agency is not 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.* Any verbal or nonverbal conduct that may cause significant emotional distress to an individual receiving services.

(i) 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.

(ii) 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.* 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* includes 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.* 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.* 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.* 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.* 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 includes, 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; or

(iii) failure to provide access to educational instruction, by a custodian with a duty to ensure that an individual receives access to such instruction in accordance with the provisions of part one of article 65 of the Education Law and/or the individual's individualized education program.

(9) *Significant incident.* 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 includes but is not limited to:

(i) the following types of incidents <u>prior</u> to January 1, 2016:

(a) conduct between persons receiving services that would constitute abuse as described in paragraphs (1) through (7) of this subdivision if committed by a custodian, except sexual activity involving adults who are capable of consenting and consent to the activity; or

(b) 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 that impairs or creates a reasonably foreseeable potential to impair the health, safety, or welfare of an individual receiving services, including:

(1) *seclusion*. 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. Unless permitted by section 633.16 of this Title, the use of seclusion is prohibited.

Note:

Section 633.16 of this Title (Person-Centered Behavioral Intervention) identifies a form of "exclusionary time out," which prevents egress from a time out room by a custodian's direct and continuous action, and requires constant visual and auditory monitoring. Use of exclusionary time out may be included in a formal behavior support plan and implemented in accordance with the conditions and limits set forth in paragraph 633.16(j)(3) of this Title. The use of exclusionary time out in the absence of an approved behavior support plan that incorporates the use of exclusionary time-out, or a failure to implement such a plan as designed, is considered to be "seclusion" and is prohibited.

(2) *unauthorized use of time-out*. For the purposes of this subclause only, 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;

Note:

For the purposes of this provision "unauthorized use of time out" includes any use of time out that is inconsistent with an individual's plan of services except as noted in subclause (*1*) of this clause.

(3) except as provided for in paragraph (7) of this subdivision, the administration of a prescribed or over-the-counter medication, that is inconsistent with a prescription or order issued for a service recipient by a licensed, qualified health care practitioner, and that has an adverse effect on an individual receiving services. For purposes of this clause, *adverse effect* means the unanticipated and undesirable side effect from the administration of a particular medication which unfavorably affects the wellbeing of a person receiving services;

(4) *inappropriate use of restraints*. 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* includes 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; and

(5) *other mistreatment*. 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 that impairs or creates a reasonably foreseeable potential to impair the health, safety, or welfare of an individual receiving services, except as described in subclauses (*1*) through (*4*) of this clause;

(c) *missing person*. 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

(d) *choking, with known risk*. The 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

(e) *self-abusive behavior, with injury*. A self inflicted injury to an individual receiving services that requires medical care beyond first aid.

(ii) the following types of incidents <u>on and after January 1, 2016</u>:

(a) conduct between persons receiving services that would constitute abuse as described in paragraphs (1) through (7) of this subdivision if committed by a custodian, except sexual activity involving adults who are capable of consenting and consent to the activity; or

(b) 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 that impairs or

creates a reasonably foreseeable potential to impair the health, safety, or welfare of an individual receiving services; including:

(1) *seclusion*. 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. Unless permitted by section 633.16 of this Title, the use of seclusion is prohibited;

Note:

Section 633.16 of this Title (Person-Centered Behavioral Intervention) identifies a form of "exclusionary time out," which prevents egress from a time out room by a custodian's direct and continuous action, and requires constant visual and auditory monitoring. Use of exclusionary time out may be included in a formal behavior support plan and implemented in accordance with the conditions and limits set forth in paragraph 633.16(j)(3) of this Title. The use of exclusionary time out in the absence of an approved behavior support plan that incorporates the use of exclusionary time-out, or a failure to implement such a plan as designed, is considered to be "seclusion" and is prohibited.

(2) *unauthorized use of time-out*. For the purposes of this subclause only, 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;

Note:

For the purposes of this provision "unauthorized use of timeout" includes any use of time out that is inconsistent with an individual's plan of services except as noted in subclause (*1*) of this clause.

(3) except as provided for in paragraph (7) of this subdivision, the administration of a prescribed or over-the-counter medication that is inconsistent with a prescription or order issued for a service recipient by a licensed qualified health care practitioner, and that has an adverse effect on an individual receiving services. For purposes of this subclause, *adverse effect* means the unanticipated and undesirable side effect from the administration of a particular medication which unfavorably affects the wellbeing of a person receiving services;

(4) *inappropriate use of restraints*. 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" includes 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; and

(5) *mistreatment*. Other conduct on the part of a custodian, inconsistent with the individual's plan of services, generally accepted treatment practices, and/or applicable Federal or State laws, regulations, or policies, and that impairs or creates a reasonably foreseeable potential to impair the health, safety, or welfare of an individual receiving services, except as described in any other provision of this subdivision;

(c) *missing person at risk for injury*. 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;

(d) *unauthorized absence*. The unexpected or unauthorized absence of a person after formal search procedures (see glossary, section 624.20 of this Part) have been initiated by the agency. Reasoned judgments, taking into consideration the person's habits, deficits, capabilities, health problems, etc., determine when formal search procedures need to be implemented. It is required that formal search procedures must be initiated immediately upon discovery of an absence involving a person whose absence constitutes a recognized potential danger, except as defined in clause (*c*) of this subparagraph, to the wellbeing of the person or others;

(e) *choking, with known risk*. The 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;

(f) *choking, with no known risk*. For the purposes of this paragraph, 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 choking, with known risk, incident (see clause [*e*] of this subparagraph), involving an individual with a known risk for choking and a written directive addressing that risk;

(g) *self-abusive behavior, with injury*. A self-inflicted injury to an individual receiving services that requires medical care beyond first aid;

(h) *injury, with hospital admission*. An injury that results in the admission of a service recipient to a hospital for treatment or observation, except as defined in clause (*g*) of this subparagraph;

(i) *theft and financial exploitation*. 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; 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;

(j) *other significant incident.* An incident that occurs under the auspices of an agency, but that does not involve conduct on the part of a custodian, and does not meet the definition of any other incident described in this subdivision, but that because of its severity or the sensitivity of the situation may result in, or has the reasonably foreseeable potential to result in, harm to the health, safety, or welfare of a person receiving services.

14 CRR-NY 624.3
Current through June 15, 2020

14 CRR-NY 624.4

624.4 Notable occurrences, defined.

(a) Notable occurrences are events or situations that meet the definitions in subdivision (c) of this section and occur under the auspices of an agency.

(b) Notable occurrences do not include events and situations that meet the definition of a reportable incident in section 624.3 of this Part even if the event or situation otherwise meets the definition of one of the categories in subdivision (c) of this section. An exception is that a death that also meets the definition of a reportable incident must be reported both as the reportable incident and as a notable occurrence.

(c) *Serious and minor notable occurrences* are defined and categorized as follows:

(1) the following types of incidents prior to January 1, 2016:

(i) *injury.*

(a) 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 of this Part) 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.

(b) 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 section 624.3(b)(9)(i)(*e*) of this Part, an injury due to self-injurious behavior that requires medical care beyond first aid is a reportable incident.

(ii) *unauthorized absence.* The unexpected or unauthorized absence of a person after formal search procedures (see glossary, section 624.20 of this Part) 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.

Note:

In accordance with section 624.3(b)(9)(i)(*c*) of this Part, an unauthorized absence that results in exposure to risk of injury to the person receiving services is a reportable missing person incident.

(iii) *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.

(iv) *choking, with no known risk.* For the purposes of this paragraph, 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 section 624.3[b][9][i][*d*] 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.

(v) *theft and financial exploitation.*

(a) 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 and less than or equal to $100, that does not involve a credit, debit, or public benefit card, and that is an isolated event.

(b) *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; 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.

(vi) *sensitive situations.* Those situations involving a person receiving services that do not meet the criteria of the definitions in subparagraphs (i)-(v) of this paragraph 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 that 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.

(vii) *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 as specified in section 624.3 of this Part or other notable occurrences as specified in this section. ICF violations are serious notable occurrences.

(2) the following types of incidents <u>on and after January 1, 2016</u>:

(i) serious notable occurrences:

(a) *death*. The death of any person receiving services, regardless of the cause of death. 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;

(b) *sensitive situations*. Those situations involving a person receiving services that do not meet the definitions of other incidents in section 624.3 of this Part or in this subdivision, but that may be of a delicate nature to the agency, and are reported to ensure awareness of the circumstances. Sensitive situations must be defined in agency policies and procedures, and include, but not be limited to, possible criminal acts committed by an individual receiving services.

(ii) minor notable occurrences:

(a) *theft or financial exploitation, 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 and less than or equal to $100, that does not involve a credit, debit, or public benefit card, and that is an isolated event; and

(b) *injury, 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 of this Part) by a physician, dentist, physician's assistant, or nurse practitioner, and such treatment is more than first aid.

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625.2 Definitions.

The following definitions apply to the terms as they are used in this Part. Definitions for other terms used in this Part may be found in the glossary in section 624.20 of this Title.

(a) Auspices, under the.

For the purposes of this Part 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.

(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 lived 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 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.

(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.

(b) Physical abuse.

The non-accidental use of force that results in bodily injury, pain or impairment, including but not limited to, being slapped, burned, cut, bruised or improperly physically restrained.

(c) Sexual abuse.

Non-consensual sexual contact of any kind, including but not limited to, forcing sexual contact or forcing sex with a third party.

(d) Emotional abuse.

The willful infliction of mental or emotional anguish by threat, humiliation, intimidation, or other abusive conduct, including but not limited to, frightening or isolating an adult.

(e) Active neglect.

The willful failure by the caregiver to fulfill the care-taking functions and responsibilities assumed by the caregiver, including but not limited to, abandonment, willful deprivation of food, water, heat, clean clothing and bedding, eyeglasses or dentures, or health related services.

(f) Passive neglect.

The non-willful failure of a caregiver to fulfill care-taking functions and responsibilities assumed by the caregiver, including but not limited to, abandonment or denial of food or health related services because of inadequate caregiver knowledge, infirmity, or disputing the value of prescribed services.

(g) Self neglect.

An adult's inability, due to physical and/or mental impairments, to perform tasks essential to caring for oneself, including but not limited to, providing essential food, clothing, shelter, and medical care; obtaining goods and services necessary to maintain physical health, mental health, emotional well-being, and general safety; or managing financial affairs.

(h) Financial exploitation.

The use of an adult's funds, property, or resources by another individual, including but not limited to, fraud, false pretenses, embezzlement, conspiracy, forgery, falsifying records, coerced property transfers, or denial of access to assets.

(i) Death.

The end of life, expected or unexpected, regardless of cause.

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